

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11876

## CERTIFICATE OF DEATH

469  
Reg. Dist. No. 28

## 1. PLACE OF DEATH:

Anne Arundel County  
Crownsville

City or town. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? nine years, 5 mos., 23 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 9 years, 5 months, 23 days

## 3. (a) FULL NAME

MINNIE ABRAMS

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Negro Single

6. (b) Name of husband or wife none

7. Birth date of deceased (mo., day, yr.) (unknown) 6. (c) If alive, give age. years

ABT. 1891

8. AGE: Years Months Days If less than one day  
57? -- -- . hrs. min.9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Hospital Records

Address Crownsville State Hospital

17. Burial (Burial, cremation, or removal) Date thereof 11/29/48  
(month) (day) (year)

Cemetery Hospital

Location Crownsville Md

18. Funeral director

Address Crownsville Md

19. Date rec'd by registrar 11/29/48

Date signed 11/19/48

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne's

City or town Centerville (If outside city or town limits, write RURAL and give nearest town)

Street No. none

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1948 at 3:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1939, to November 19, 1948

and that I last saw her alive on November 19, 1948.

Immediate cause of death

Schizophrenia, ~~Chastion~~  
Cancer of Pancreas

Due to

Due to

Other conditions ~~Possible Cancer of~~  
Schizophrenia  
(Include pregnancy within 6 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

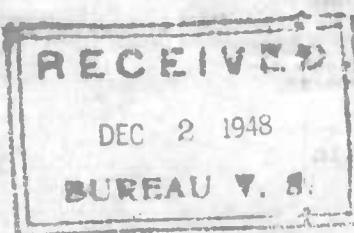
23. SIGNATURE

Address Crownsville, Maryland

M. D. or other

Date signed

16A  
TG  
SHB



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The connect page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11677

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Behind Colgan's store - west st.

How long in hospital or institution?

## 3. (a) FULL NAME

William Allsup4. Sex M 5. Color or race C 6. (a) Single, married, widowed, or divorced Single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 19 1907 6. (c) If alive, give age — years8. AGE: Years 41 Months 4 Days — If less than one day hrs. — min.9. Birthplace ANNAPOLIS, MARYLAND  
 (Town, county, and state)

## 10. Usual occupation

11. Industry or business NONE12. Name THOMAS ALSOP13. Birthplace ANNAPOLIS14. Maiden name ANNIE Queen15. Birthplace ANNAPOLIS, MARYLAND16. Informant HELEN RICKSAddress 58 CLAY Street17. Burial, cremation, or removal? BURIAL Date thereof 11-23-1948  
 (Burial, cremation, or removal. Which?)Cemetery or crematory AsburyLocation Smithville18. Funeral director Mrs. Charles E. HicksAddress 43-45 Northwest Street19. Nov. 23 1948 7:30 P.M.  
 (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)Street No. 26 Calvert St.

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov. 21 1948 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

Cerebral Hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

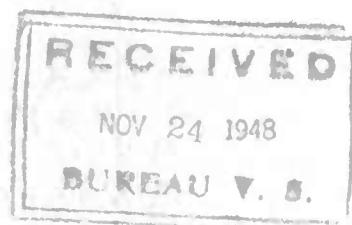
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. Peyton Ritchings, M.D.  
 Address Annapolis, Md. Date signed 11/23/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The current page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11078

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel  
 County: Mulberry Hill near Annapolis, Md.  
 City or town: (If outside city or town limits, write RURAL and give nearest town) 20 Years  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred: Mulberry Hill near Annapolis  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State: Maryland County: Anne Arundel  
 City or town: Mulberry Hill near Annapolis  
 Street No.: (If outside city or town limits, write RURAL and give nearest town) Mulberry Hill near Annapolis  
 (If rural, give LOCATION) ✓  
 2.(a) If veteran, name war: World War I

3. (a) FULL NAME  
 Grafton Duvall Anderson

3. (b) Social Security Number  
 None

4. Sex: Male 5. Color or race: Colored 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Bertha Anderson

7. Birth date of deceased (mo., day, yr.): June 6, 1891 6.(c) If alive, give age: 40 years

8. AGE: Years: 57 Months: 5 Days: 3 It less than one day: hrs: min:

9. Birthplace: Brownie Woods A.A. Co. Md. (Town, county, and state)

10. Usual occupation: Minister

11. Industry or business: None

MOTHER FATHER: Matthew Anderson

12. Name: St. Margrets A.A. Co. Md.

13. Birthplace: Mary Kathrine Stansbury

14. Maiden name: Kent Island, Eastern Shore, Md.

15. Birthplace: Bertha Anderson

16. Informant: Mulberry Hill A.A. Co. Md.

Burial: 11-12-1948  
 (Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year)

Cemetery or crematory: Broad Neck Cemetery

Location: St. Margrets --- near Annapolis

18. Funeral director: Mrs. Charles E. Hicks

Address: 43-45 Northwest Street

19. Nov. 12, 1948  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/9 1948, at 9:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/9 1948 to 11/9 1948

and that I last saw him alive on 10/9/48 1948

Immediate cause of death: Coronary Insufficiency DURATION 1 day

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings or operations: Date of op.

Autopsy results: PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of...

Where did injury occur? (City or town) (County) (State)

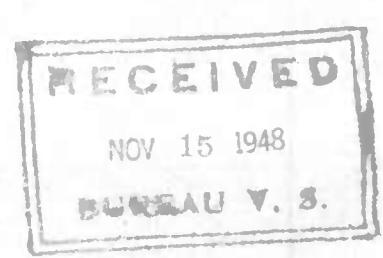
Injured at home, farm, industry, public place (where?)

Mans of injury: Injured at work?

23. SIGNATURE: *George H. Johnson, M.D.* M.D. or other

Address: 40 Northwest Street, Annapolis, Md. Date signed: 11/10/48

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Basel

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

528  
11679

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County

Anne Arundel

City or town

Annapolis, Md.

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Robert F. Atwell

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Bertha M. Atwell

6. (c) Native, give age..... years

T. Birth date of deceased (mo., day, yr.)

January 16<sup>th</sup> 1878

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

A.A.C. Md.

(Town, county, and state)

10. Usual occupation

Boat Builder, Carpenter.

11. Industry or business

Robert F. Atwell

MOTHER FATHER

12. Name

Robert F. Atwell

13. Birthplace

A.A.C. Md.

14. Maiden name

Minnie Kirchner

15. Birthplace

A.A.C. Md.

16. Informant

Bertha M. Atwell

Address 103 8th Bomber Ave Eastport Md.

17. Burial

Date thereof 11-11-48

(Burial, cremation, or removal. Which)

(month) (day) (year)

Cemetery or crematory

Glen Haven Memorial

Location

Glen Burnie A.A.C. Md.

18. Funeral director

John M. Taylor Son

Address

Annapolis, Md.

19. (Date rec'd by registrar)

19-48

Date signed 11-9-48

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Anne Arundel

County

Anne Arundel

City or town

Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1038 Bomber Ave

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

Nov 8 1948 at 11 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1948 to Nov 8 1948

and that I last saw him alive on Nov 8 1948

Immediate cause of death

Circumference of Blood Dr.

DURATION

Several hours

Due to

Due to

Other conditions

Several hours

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

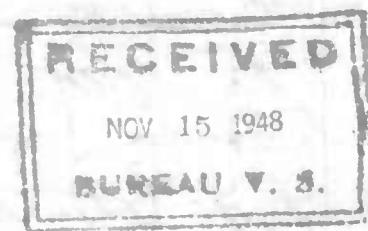
23. SIGNATURE

M. D. or other

Address

Annapolis, Md.

Date signed 11-9-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 11080 Reg. Dist. No. 23

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County A. A.City or town Kingsbridge

(If outside city or town limits, write RURAL and give nearest town)

8 yrs.

How long in above place of death? 803 Camp Mead Rd.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Willie Philip Ballard

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male w Widowed

6.(b) Name of husband or wife

Willie Gun

7. Birth date of deceased (mo., day, yr.)

Aug. 18 - 1851

6.(c) If alive, give age years

8. AGE:

Years 97Months 3

Days

If less than one day

hrs. min.

9. Birthplace

Va - Albemarle Co.

(Town, county, and state)

10. Usual occupation

Father -

11. Industry or business

Wm P. Ballard

12. Name

Wm P. Ballard

13. Birthplace

Va

14. Maiden name

Mary Vea

15. Birthplace

Va

16. Informant

N. K. Ballard

Address

213 - Todd av. Charlottesville

Burial notice

16 - 48

(Burial, cremation, or removal. Which?)

Date thereof 11/10/48

(month) (day) (year)

Cemetery or crematory

Mt. Maria Cemetery

Location

White Hall Va

18. Funeral director

Wm. L. Ball Jr. Co.

Address

Riversdale Md

19. Date rec'd by registrar

Nov 13 1948

(Date rec'd by registrar)

W. Brashears

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty Arundel CoCity or town Linthicum

(If outside city or town limits, write RURAL and give nearest town)

Street No. 803 - S. Camp Mead Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 13 1948

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Oct. 1945 to Nov. 13 1948and that I last saw him alive on Nov. 13 1948

Immediate cause of death

Cardio - Vascular Disease

DURATION

3 days

Due to

Due to

Other conditions Bronchial asthma 10 gm.

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

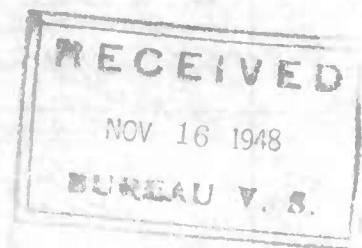
Injured at work?

23. SIGNATURE

Chas. L. Ball Jr. M.D.

M. D. or other

Address Linthicum Date signed 11-13-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11081

Reg. Dist. No. ....

21

## CERTIFICATE OF DEATH

83a

1. PLACE OF DEATH:  
Anne Arundel  
County.....

City or town..... Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:  
Emergency Hospital

How long in hospital or institution?..... — D.O.A.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel

City or town..... Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

Street No. .... 25 Dean St.  
(If rural, give LOCATION)

2.(a) If veteran, name war..... —

3. (a) FULL NAME

LILLIAN BLAY

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6. (b) Name of husband or wife..... Neil Blay

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... March 29, 1881

8. AGE: Years Months Days If less than one day

67 7 3

9. Birthplace..... Ireland  
(Town, county, and state)

10. Usual occupation..... House-wife

11. Industry or business..... —

12. Name	Unknown
13. Birthplace	Unknown

14. Maiden name	Unknown
15. Birthplace	Unknown

16. Informant..... Papers of Mrs. Lillian Blay

Address..... 25 Dean St. Annapolis, Md.

17. Burial..... Cedar Bluff Cemetery  
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Cedar Bluff Cemetery

Location..... Annapolis, Maryland

18. Funeral director..... Ben L. Hopping and Son

Address..... 170-172 West St. Annapolis, Maryland

Nov. 5 1948

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 2 1948 at 1 p.m.

21. I CERTIFY that death occurred on the date above stated, Post mortem Examination  
Nov. 2, 1948.

Immediate cause of death..... Cerebral accident

Due to..... Arterio-sclerosis (general) unknown

Due to..... Arterial hypertension unknown

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... John H. Claffey, M.D. Deputy Medical Examiner

M. D. of other.....

Address..... Annapolis, Md. Date signed..... Nov. 4, 1948



Evidence for correction of MARYLAND STATE DEPARTMENT OF HEALTH  
spelling of given name shown on: 2411 N. Charles St., Baltimore

11082

## FILM NO. G 118 DEC - 3 1948 CERTIFICATE OF DEATH

93d  
Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County..... Anne Arundel  
City or town..... Rural - Davidsonville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

Home - Farm of Joseph Bottner

How long in hospital or institution?

## 3. (a) FULL NAME

KRESZENZ ~~+~~ Joseph Bottner

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W S

6. (b) Name of husband or wife

Rural

7. Birth date of deceased (mo., day, yr.)

July 17, 1857

6. (c) If alive, give age..... years

8. AGE:

Years  
91Months  
4Days  
11

It less than one day

hrs. min.

9. Birthplace.....

Germany

(Town, county, and state)

10. Usual occupation.....

Retired) Housekeeping

11. Industry or business

Unknown

MOTHER FATHER

12. Name.....

Unknown

13. Birthplace.....

- -

14. Maiden name.....

Unknown

15. Birthplace.....

- -

16. Informant.....

Joseph Bottner

Address.....

Baltimore post office Maryland

17. Burial

(Burial, cremation, or removal, which?)

Date thereof..... Nov 20/48  
(month) (day) (year)

Cemetery or crematory.....

St. Mary's

Location.....

Annapolis, Md.

18. Funeral director.....

D. L. Thompson

Address.....

Annapolis, Maryland

Nov. 29 1948

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel

City or town..... Rural - Davidsonville  
(If outside city or town limits, write RURAL and give nearest town)Street No..... Farm of Joseph Bottner  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

Nov. 28 1948 at 10 20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 6 1948, to Nov. 28 1948

and that I last saw her alive on Nov. 16 1948

Immediate cause of death.....

cardiorespiratory failure

Due to.....

Arteriosclerotic cardio -

Due to.....

vascular disease -

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

E. Peyton Ritchings, M.D.

M. D. or other

Address.....

Annapolis, Md.

Date signed..... Nov. 28, 1948

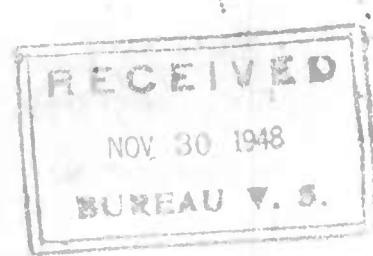
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

11083

Reg. Dist. No. ....

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

Anne Arundel

City or town

Leverett Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 years

Hospital, institution, or street address where death occurred:

Carlton Manor

How long in hospital or institution?

## 3. (a) FULL NAME

Mrs. Rosa Blanche Broecker

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.

W.

Married.

6. (b) Name of husband or wife

Roland Broecker

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

June 19 - 1890 60 years

8. AGE:

Years

Months

Days

If less than one day

58

4

13

hrs.

min.

9. Birthplace

(Town, county, and state)

Brooklyn, Md.

Housewife

10. Usual occupation

11. Industry or business

12. Name

Joseph J. Ward

13. Birthplace

Belvoir County, Md.

14. Maiden name

Marie Watson

15. Birthplace

Anne Arundel Co., Md.

16. Informant

Mrs. Roland Broecker,

Address

Leverett Park, Md.

17. (Burial, cremation, or removal which?)

Date thereof

11-5-48.

(month) (day) (year)

Cemetery or crematory

Cross Roads Cem.

Location

26, Uppergrate Rd.

J. C. C. Cemetery

18. Funeral director

Address

105 B. Foot Ave.

19. (Date record by registrar)

19

X

A.W. Heddach

Dm

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

101

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

Nov. 2<sup>nd</sup> 1948 at Noon21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18, 1948, to October 30, 1948, and that I last saw her alive on 1<sup>st</sup> of 30<sup>th</sup> 1948.

Immediate cause of death

coronary disease

DURATION

6 years

Due to

congestion of the heart

6 years

Due to

pulmonary edema.

2 months

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

No

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

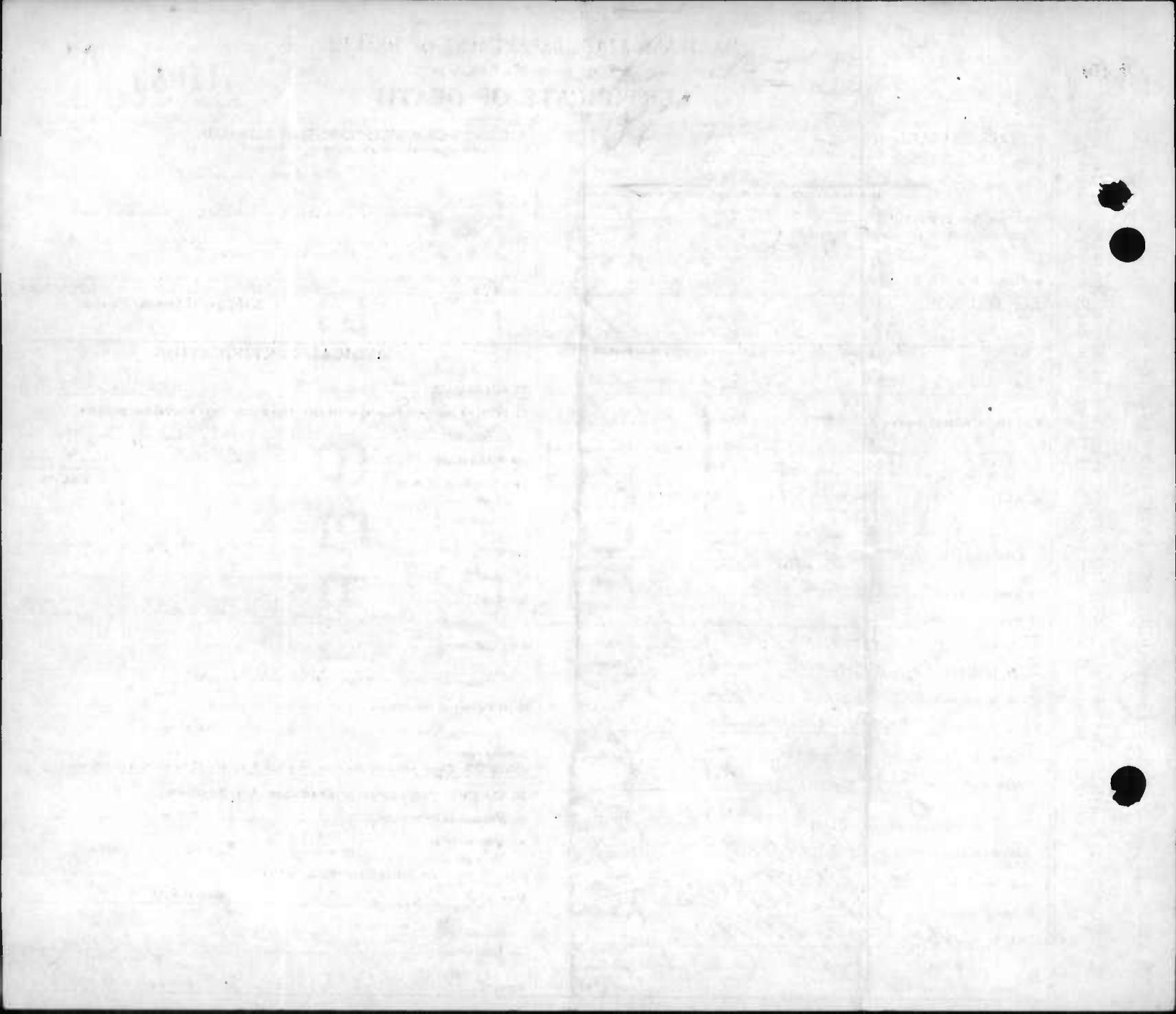
Injured at work?

23. SIGNATURE

Gustave H. Faukner, M.D. or other

Address

Baltimore, Md. Date signed 11/2/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death, clearly and legibly. is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11084

Reg. Dist. No. 21

## CERTIFICATE OF DEATH

83a

## 1. PLACE OF DEATH: Anne Arundel Co.

County

Annapolis

City or town

Life

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address, where death occurred:

18 Lafayette Ave.

How long in hospital or institution?

## 3. (a) FULL NAME

Mattie Brown

4. Sex

Female

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Married

Charles Brown

6.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 2, 1901

8. AGE: Years

47

Months

4

Days

18

If less than one day

hrs.

min.

9. Birthplace Skidmore, A.A.Co. Maryland

(Town, county, and state)

Housewife

10. Usual occupation

11. Industry or business

None

12. Name

Alton Johnson

13. Birthplace

Skidmore, A.A.Co. Maryland

14. Maiden name

Lillian Colbert

15. Birthplace

Skidmore A.A.Co. Maryland

16. Informant

Charles Brown

Address

18 Lafayette Ave.

Burial

Date thereof 11-24-1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Brewer Hill Cemetery

Cemetery or crematory

Location West Street Extended

18. Funeral director

Mrs. Charles E. Hicks

Address 43-45 Northwest Street

19. Nov. 28 1948

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

Anne Arundel

County Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 18 Lafayette Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

November 20 1948 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
only on Nov. 20, 1948, to, 1948.

and that I last saw h alive on 1948.

Immediate cause of death

Cerebral Hemorrhage

DURATION

1/2 hr.

Due to

arterial filo (hemorrhage)

3 hr.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

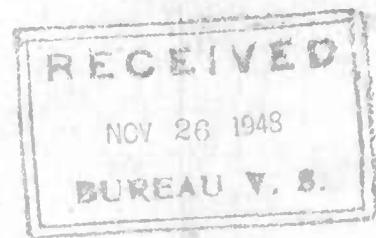
Means of injury

Injured at work

23. SIGNATURE

R. E. Richardson, M.D.

Address 10 - 1st and 2nd St., Annapolis, Md. Date signed Nov. 23, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, in the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH *bc*

2411 N. Charles St., Baltimore

11086

28

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

Anne Arundel County.....

Crownsville City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mos. 20 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or Institution? 8 mos. 20 days

## 3. (a) FULL NAME

JOHN BROWN

## 4. Sex

Male

## 5. Color or race

Negro

## 6.(a) Single, married, widowed, or divorced

Divorced

## 6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

## 7. Birth date of deceased (mo. day, yr.)

1890

## 8. AGE:

Years  
58

Months

Days

If less than one day

..... hrs. ..... min.

## 9. Birthplace.....

Howard County, Maryland

(Town, county, and state)

laborer

## 10. Usual occupation.....

## 11. Industry or business.....

## MOTHER FATHER

12. Name ..... John Brown

13. Birthplace ..... Maryland

14. Maiden name ..... Rebecca Brown

15. Birthplace ..... Maryland

## 16. Informant.....

Hospital Records

## Address

Crownsville, Maryland

## 17. Burial

(Burial, cremation, or removal, Which?)

Date thereof ..... 11-28-48

(month) (day) (year)

Cemetery or crematory

Mt Calvary Cemetery

Location

Cedar Hill Md.

## 18. Funeral director

A. W. F. Funeral

Address 918 Grand Hill Ave.

## 19. Nov. 22 1948

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County ..... -----

City or town ..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4649 Falls Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... November 17

1948 at 7:49 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 27

1948 to November 17 1948

and that I last saw him alive on November 17 1948

Immediate cause of death ..... Chronic Myocarditis

known to us since

DURATION

July 1948

Due to.....

Due to.....

Other conditions ..... Senile Psychosis

known to us since

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Jacob Mangersten, M.D.

M. D. or other

Address ..... Crownsville, Md. Date signed ..... Nov. 17/48

Registrar

PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Be 11085  
28  
Reg. Dist. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 8 mo. 15 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 5 yrs. 8 mo. 15 days

## 3. (a) FULL NAME

MARY ANN BROWN (MARIE) #5

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Negro	Widowed

6. (b) Name of husband or wife

T. Birth date of deceased (mo., day, yr.) about 1891

6. (c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
57?	--	--	hrs. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Maid

11. Industry or business

12. Name	John Morgan
13. Birthplace	Maryland

14. Maiden name	Sarah Briscoe
15. Birthplace	Maryland

16. Informant Hospital Records

Address	Crownsville, Maryland
17. Burial	Date thereof 11/18-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or cemetery	Hospital
Location	Crownsville Md

18. Funeral director	Super Hospital
Address	Crownsville Md

19. (Date rec'd by registrar)	11/18 48
-------------------------------	----------

E. F. Joyce Local Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1421 East Fayette Street

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

November 11, 1948, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 26, 1943, to November 11, 1948, and that I last saw her alive on November 11, 1948.

Immediate cause of death

Uremia  
known to us since

Due to

Due to

Other conditions General Paresis  
known to us since

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

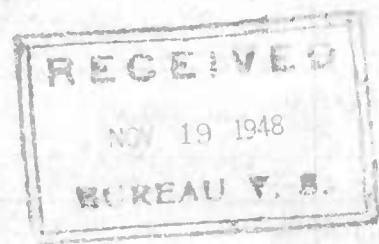
23. SIGNATURE

Jacob Mumpus

M. D. or other

11/11/48

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11087

## CERTIFICATE OF DEATH

61

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County.....

City or town.....

St. Margaret

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mrs. Irene Butler

4. Sex

Female

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

Morrie Butler

7. Birth date of deceased (mo., day, yr.)

Oct 18, 1892

6. (c) If alive, give age..... years

8. AGE:

Years 56 Months 12 Days 12 If less than one day

hrs. min.

9. Birthplace

St. Margaret, Md. Co.

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

George Hennan

12. Name

George Hennan

A. A. Co.

13. Birthplace

Maryland Fleetwood

A. A. Co.

14. Maiden name

Mary C. Fleetwood

A. A. Co.

15. Birthplace

Mary C. Fleetwood

A. A. Co.

16. Informant

Margaret Butler

Margaret Butler

A. A. Co.

Margaret Butler

Margaret Butler

Address

St. Margaret

Burial

Burial, cremation, or removal. Which?

Henson's family Cem.

Cemetery or crematory

St. Margaret, Md. Co.

Location

J. B. L. L. Mar

18. Funeral director

C. C. J. Mar

Address

Nov. 12 1948

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

St. Margaret

City or town.....

St. Margaret

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 10<sup>th</sup> 1948 at 10<sup>50</sup> M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 1st 1948 to Nov 10<sup>th</sup> 1948and that I last saw her alive on Nov 9<sup>th</sup> 1948

Immediate cause of death

respiratory failure

Due to

hypertension

Due to

Diabetes

Other conditions neoplasm of pancreas

(Include pregnancy within 3 months of death)

Major findings of operations tumor of pancreas

J. B. L. Mar Date of op. 1948

Autopsy results

not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

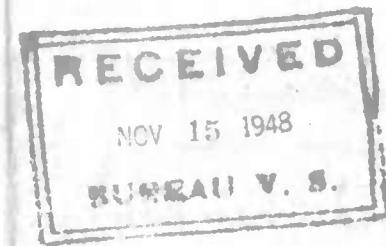
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edith Butler, M.D.

M. D. or other

Address 42 State Circle, Annapolis Date signed 11-12-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11088

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County

Anne Arundel

City or town

Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Charles Campion

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Col

Widowed

6. (b) Name of husband or wife

Elizabeth Carol

7. Birth date of deceased (mo., day, yr.)

Mar 4, 1877

6. (c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

7

8

5

hrs.

min.

9. Birthplace

West River Md

(Town, county, and state)

10. Usual occupation.

Farm Laborer

11. Industry or business

MOTHER FATHER

12. Name

J. Campion

13. Birthplace

Unknown

14. Maiden name

Frances Carol

15. Birthplace

Unknown

16. Informant

Sam'l. Neal

Address

Cumberland Md.

17. Burial

Burial

Date thereof (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Catholic Cemetery Owingsville Md

Location

Owingsville Md

18. Funeral director

J. A. Hauder, &amp; Son

Address

Salisbury Md

19. Date rec'd by registrar

11/11/48

19 48

(Date rec'd by registrar)

O'Donnell

n Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

City or town

Bridgewater

Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 9

19 48 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 5, 1948, to Nov. 9, 1948,

and that I last saw him alive on Nov. 9, 1948.

19 48

Immediate cause of death

Bronchitis pneumonia

Due to: arteritis - arteriosclerosis

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE: Emil A. Neale, M.D.

M. D. or other

Address

Dover, Md.

Date signed 11-8-48

2

3

4

5

6

7

8

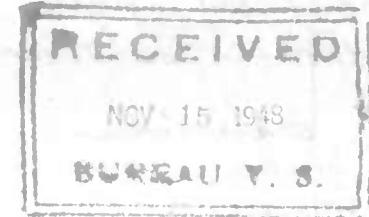
9

10

11

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11090

Reg. Dist. No. 31

## CERTIFICATE OF DEATH

552

## 1. PLACE OF DEATH:

County

Anne Arundel

City or town

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

27 Cherry Grove Ave

How long in hospital or institution?

## 3. (a) FULL NAME

Howard W. Christy Sr.

## 3. (b) Social Security Number

214-05-0215

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Bertha E. Christy

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

July 10<sup>th</sup> 1892

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Baltimore Maryland

(Town, county, and state)

10. Usual occupation

Manager American Oil Co.

11. Industry or business

Annapolis Maryland

MOTHER FATHER

12. Name

Thomas Henry Christy

13. Birthplace

Baltimore Md.

14. Maiden name

Amelia E. Truel

15. Birthplace

Maryland

16. Informant

Mrs. Bertha E. Christy

Address

27 Cherry Grove Ave. Annapolis Md.

Burial

Date thereof Nov 24-1948

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Western Cemetery

Location

Baltimore Md.

18. Funeral director

John W. Fox Jr. Son

Address

Annapolis Md.

19. Nov 23 1948

Nov 23 1948

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Anne Arundel

City or town

City or town

Annapolis Md.

Street No.

Street No.

27 Cherry Grove Ave

(If rural, give location)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

November 20<sup>th</sup> 1948 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1.

to

1948 to 1949

and that I last saw him alive on

Nov 20

1948 to 1949

Immediate cause of death

Myeloma (multiple)  
Due to Anemia Crusts bone  
abs & debris

DURATION

Several months

Date to

Other conditions *Anterior features*  
*small abs*

2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'l place (where?)

Means of injury

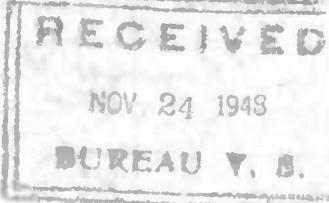
Injured at work?

23. SIGNATURE

M. D. or other

Address George G. Bostick

Date signed 11-22-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11091

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County

Anne Arundel

City or town

Annesland Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Cedar Crest Nursing Home

How long in hospital or institution?

## 3. (a) FULL NAME

Henry Simeon Crozier

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. W. Married

6. (b) Name of husband or wife

Lillian Jane Thresher

6. (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.)

May 27, 1872 ?

8. AGE:

Years  
76?

Months

Days

If less than one day

hrs. min.

9. Birthplace

Georgia

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name --- Crozier

13. Birthplace Georgia

MOTHER

14. Maiden name Unknown

FATHER

15. Birthplace Georgia

16. Informant

Mary N. Pickles

Address

711 Longfellow St. N.W.

17. Burial

Date thereof

11/17/48  
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Rome, Georgia

Location

18. Funeral director

John J. O'Hearn Company

Address

2901 14th St. N.W.

19. 11/18

19. 48

(Date rec'd by registrar)

Z. J. O. A. B.  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Prince Georges

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. (Boliverville)

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1948 at 7:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 to 1948, to Nov. 15, 1948, and that I last saw h. m. alive on Nov. 12, 1948.

Immediate cause of death

Mitral Insufficiency

Due to

Enlarged heart

Due to

Intestinal obstruction

Other conditions

General arterio - sclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Gustavus P. Dauchard M.D.

M. D. or other

Address 1168 Bunker Rd. Date signed 11/15/48



John

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

11092

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County. Anne Arundel

City or town. Annapolis, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Charles E. Dosey

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

colored

widowed

8. (b) Name of husband or wife

Sarah Dosey

8. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

May 1, 1897

8. AGE: Years

5

Months

6

Days

21

It less than one day

hrs.

min.

9. Birthplace

Chesterfield, Md.

(Town, county, and state)

10. Usual occupation

Cook

11. Industry or business

12. Name

Abraham Dosey

13. Birthplace

Md.

14. Maiden name

Mary Setters

15. Birthplace

Md.

16. Informant

Alice Blake

Address

Parole, Md.

17. Burial

Burial

Date thereof Nov. 1, 1948

(month) (day) (year)

Cemetery or crematory

Davidsonville Cemetery

Location

Davidsonville, Md.

18. Funeral director

J. B. Johnson

Address

Annapolis, Md. Box 462

19. Nov. 5

1948

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State. Maryland

County. Anne Arundel Co.

City or town. Annapolis, Md. Parole

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

November 3,

19

48, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/3 1948 to 11/3 1948

and that I last saw him alive on November 3, 1948

Immediate cause of death

Coronary Insufficiency

Due to Coronary Occlusion

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'l place (where?)

Means of injury

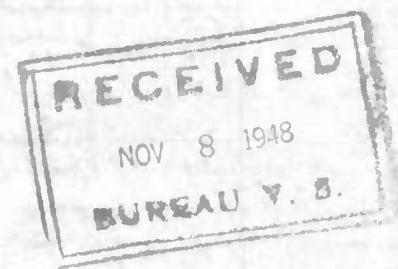
Injured at work?

p. SIGNATURE

Andrew S. Brown, M.D.

M. D. or other

Address 40 Northwest Street Date signed Nov. 5, 1948



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11003

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Greenland Beach

City or town Ad. Ad.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

ETHEL LEONA DOXEN

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife... Wm. J. Jackson

7. Birth date of deceased (mo., day, yr.)

July 2 - 1894

6. (c) If alive, give age years

8. AGE:

54

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace Md

(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

12. Name Wm. Jackson

13. Birthplace Md

14. Maiden name

15. Birthplace Md

16. Informant George E. Doxen

Address Greenland Beach Md

17. Burial

Date thereof Nov. 30 1948  
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Morelands

Location Taylor Ave

18. Funeral director Leo G. Cook

Address 1701-03 N Patterson Park Ave

19. Nov. 29 1948  
(Date rec'd by registrar)9. W. Wedrich  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Ad. Ad.

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Greenland Beach

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1948 at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 22 1948 to Nov. 25 1948

and that I last saw h. ER alive on Nov. 27 1948

Immediate cause of death

HEART FAILURE

DURATION

Due to Cerebral Hemorrhage

1 week

Due to Bronchopneumonia

1 week

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Brady Smith M.D.

M. D. or other

Address River Beach, Md. Date signed 11/28/48

1. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

## CERTIFICATE OF DEATH

Reg. Dist. No. 211094

## 1. PLACE OF DEATH: Anne Arundel

County.....

Annapolis

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

24 Hours

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Emergency Hospital

2 Hours

How long in hospital or institution?.....

## 3. (a) FULL NAME

MARY LOU EVANS

4. Sex

5. Color or race

Female

Colored

6.(a) Single, married, widowed, or divorced

Widowed

William Evans

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

January 1, 1889

8. AGE: Years

59

Months

11

Days

4

If less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation

Midwife

11. Industry or business

None

12. Name

Mike Wallace

13. Birthplace

Calvert Co. Md.

14. Maiden name

Harried

15. Birthplace

Lothian A.A. Co. Md.

16. Informant

Agnes Brandford

Address

49 College Creek Terrace

17. Burial

Date thereof.....

11-9-1948  
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Looses Cemetery

Location

Drury A.A. Co. Md.

18. Funeral director

Mrs. Charles E. Hicks

Address

43-45 Northwest Street

19. (Date rec'd by registrar)

Nov. 9 1948

70-0, Drury

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Anne Arundel

City or town.....

Lothian A.A. Co. Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Lothian A.A. Co. Md.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Nov 5

1948 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Cert 2.5 1948 to Nov. 5 1948

and that I last saw her alive on Nov. 5 1948

Immediate cause of death.....

acute myocarditis

Due to..... diabetes mellitus

Due to..... arteriosclerosis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

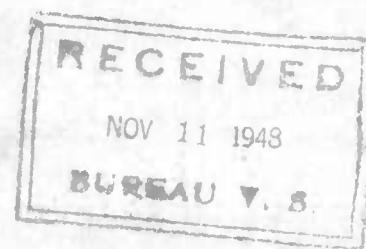
Injured at work?

23. SIGNATURE: Emily H. Wilson, M.D.

M. D. or other

Address.....

Cathias, Md. Date signed 11/7/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death, clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11695

518

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:  
Anne Arundel  
County.....  
Crownsville, Rd.  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 yrs  
Hospital, institution, or street address where death occurred:  
Crownsville, Rd. off Defence Hy

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
Maryland County Anne Arundel  
State.....  
Rural  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Annapolis RFD # 1  
If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME  
JOSEPH S. FISCHER

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife..... Mary A. Fischer

7. Birth date of deceased (mo. day. yr.) Feb 20, 1878 8. (c) If alive, give age 75 years

8. AGE: Years 70 Months 9 Days 0 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farming

MOTHER FATHER 12. Name..... Frederick Fischer

13. Birthplace Germany

14. Maiden name..... Rohr

15. Birthplace Baltimore, Maryland

16. Informant Mr. Bernard J. Fischer (Son)

Address RFD #1 Annapolis, Maryland

17. Burial Date thereof 11-23-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Our Lady of The Fields

Location Millersville, A.A. Co., Maryland

18. Funeral director Ben L. Hopping and Son

Address 170-172 West St. Annapolis, Maryland

19. Nov. 21, 1948  
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mr. 20 1948, at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945 to Jan 20 1948 and that I last saw him alive on Jan. 15 1948

Immediate cause of death

6. General metastasis

Due to

Caecum and Prostate

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

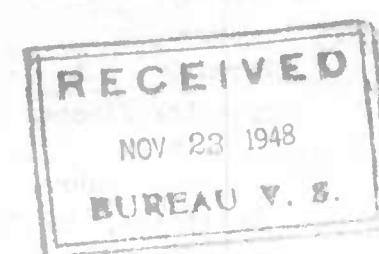
Means of injury Injured at work?

23. SIGNATURE M. N. Flanagan, M.D.

M. D. or other

Address Annapolis Date signed 11/22/48

Registrar



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

164C

Registered No. 16196

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
 (a) Baltimore City, Maryland  
 (b) Street address St. Margaret's  
 (c) Hospital or institution: Anne Arundel Co., Md.  
 (d) Length of stay in hospital or inst. (yrs., mos., or days)  
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Md. (b) County Anne Arundel  
 (c) City or town St. Margaret's  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No.  
 (e) Citizen of foreign country? (If rural give location)  
 If yes, name country (Yes or No)

3 (a) FULL NAME

VIRGINIA

LEE

GLICK

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex 5. Color or race 6 (a) Single, married, widowed, or divorced.  
Female White Married

6 (b) Name of husband or wife Jacob E. Glick

6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1920

8. AGE: Years Months Days If less than one day  
28 3 8 hr. min.

9. Birthplace Mt. Carmel, Illinois  
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Roy D. Short

13. Birthplace Indiana

14. Maiden Name VERA ~~Pradav~~ FRAVEL

15. Birthplace Indiana

16 (a) Informant Jacob E. Glick

(b) Address St. Margaret's, A.A.Co., Md.

17 (a) Removal (b) Date thereof 11-16-48  
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel, Illinois

Location

18 (a) Funeral director B. L. HOPPING & SON

(b) Address 170-172 West St., Annapolis

19 (a) Nov. 16, 1948 (b) *John French*  
(Date rec'd by registrar)

Registrar

GLICK

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1948, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined  and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

*Bullet wound of brain*

Due to

Other Conditions

(Include pregnancy within 6 months of death)

22. If an external cause was primary  or contributing  cause of death, fill in the following:

(a) Date of injury 11-15-48 at 12 Noon M.

(b) Where did injury occur? St. Margaret's, A.A.Co.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Firearms

23. Signature *John French* M.D.

Date signed 11-16-48

Medical Examiner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11097

## CERTIFICATE OF DEATH

107  
Reg. Dist. No. 22

## 1. PLACE OF DEATH:

County

Anne Arundel

rural

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years 2 mo 9 days

Hospital, institution, or street address where death occurred:

District Training School

How long in hospital or institution? 6 years 2 mo 9 days

## 3. (a) FULL NAME

William Buckner Green

4. Sex

M

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.)

May 24, 1936

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

none

MOTHER FATHER

12. Name

Arthur B. Green

13. Birthplace

Washington, D.C.

14. Maiden name

Norma Fletcher

15. Birthplace

Washington, D.C.

16. Informant

D. T. S. records

Address

Laurel, Md.

17. Removal

Date thereof Nov. - 8-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Washington, D.C.

Location

W. Va. Co. hamlets Co.

18. Funeral director

Address 517-11th St. S.E. Washington, D.C.

19. Nov 8

1948

Date rec'd by registrar

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C.

County D.C.

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 923 - 8th St. N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

Nov 8

1948 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Out. 1946 to Nov 8 1948

and that I last saw him alive on Nov 7 1948

Immediate cause of death

Bilateral bronchopneumonia

DURATION

Nov 4, 1948

Due to

Due to

Other conditions pseudo hypertrophic muscular dystrophy, birth  
mental deficiency - 112.6412  
(Include pregnancy within 3 months of death)

Major findings or operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

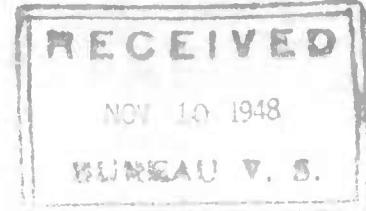
J. A. Fletcher, M.D.

M. D. or other

Address

D. T. S. Laurel, Md.

Date signed Nov 8-48



I

Dr Purvis  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The content page is especially important. Physicians: please write the causes of death clearly and legibly.

11698

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830  
Reg. Dist. No. 21

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County *Anne Arundel*  
City or town *Annapolis Md.*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Eugene J. Griffen*

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

*Male**White Widower**Amelia Louise Griffen*

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

*Dec 15<sup>th</sup> 1859*

(b) If alive, give age years

## 8. AGE:

Years	Months	Days	If less than one day
88	10	21	hrs. min.

## 9. Birthplace

*Baltimore Md.*

(Town, county, and state)

## 10. Usual occupation

*Pet Merchant at U.S. Naval Academy Annapolis Md.*

## 11. Industry or business

*Naval Academy Annapolis Md*

## MOTHER FATHER

12. Name *Thomas Griffen*13. Birthplace *Maryland*14. Maiden name *Dollie Boyd*15. Birthplace *Maryland*16. Informant *Mrs Bertha M. Jewell*Address *49 Franklin St. Annapolis Md.*17. Burial *Cemetery or crematory*Date thereof *11-17-48*

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Location *Cedar Bluff Md.*18. Funeral director *John M. Taylor Son*Address *Annapolis Md.*19. Date rec'd by registrar *Nov 7 1948*

(Date rec'd by registrar)

w Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Anne Arundel*City or town *Annapolis* (If outside city or town limits, write RURAL and give nearest town)Street No. *49 Franklin* (If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

*Nov 5<sup>th</sup> 1948*

21. I CERTIFY that death occurred on the date above stated: that attended deceased from

*Oct 20 1948 to Nov 5 1948*and that I last saw him alive on *Nov 5 1948*

Immediate cause of death

*Cardiovascular Failure  
Cerebral Hemorrhage  
With heart failure past 6 months**Due to: Arteriosclerosis**Other conditions: Arteriosclerosis**Other conditions: Arteriosclerosis**Other conditions: Arteriosclerosis*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

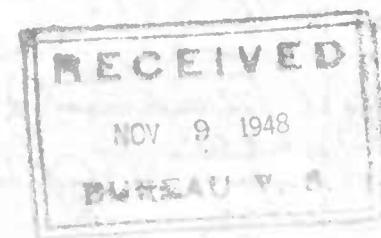
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Helen Purvis* M. D. or otherAddress *Annapolis Md.* Date signed *11/6/48*



CERTIFICATE OF BIRTH AND DEATH  
MARYLAND STATE DEPARTMENT OF HEALTHCERTIFICATE OF ~~STILLBIRTH~~ DEATH

(157C)

Reg. Dist. No. 21

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

## 1. PLACE OF BIRTH:

County ANNE ARUNDEL

City or town ANNAPOLIS, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution:

Length of mother's stay in County  
(How many years, or months, or days. SPECIFY WHICH)

3. Name of child Howard Laurence Grinnell III

5. Sex Male 6. Twin or triplet --

## FATHER OF CHILD

8. Full name Howard Laurence Grinnell Jr.

9. Color White 10. Age at time of this birth 30 yrs.

11. Usual occupation U.S. Navy

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1  
(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of Polyhydramnios

19. Labor: (a) Complications of None  
(b) Induced? Yes20. (a) Was there an operation for delivery? No  
(b) State all operations, if any None(c) Did child die before operation? No  
During operation? No23. (a) Burial (b) Date thereof Mar 4 1948  
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Naval Academy

24. (a) Funeral director John M. Murphy  
(b) Address Annapolis 372

## 2. USUAL RESIDENCE OF MOTHER:

State FLORIDA

County ESCAMBIA

City or town PENSACOLA  
(If outside city or town limits, write RURAL and give nearest town)Street No. 111 Second Street  
(If RURAL give LOCATION)

4. Date of birth 2 November 1948 Hour 8:55 P.M.

7. No. of weeks pregnancy 38

## MOTHER OF CHILD

12. Full maiden name Dorothy Elizabeth Day

13. Color White 14. Age at time of this birth 27 yrs.

15. Usual occupation Housewife

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes ANEcephalus

(b) Maternal causes None

22. I certify to the birth of this child who was born dead\* on the date and hour above stated.

Signature GEORGE N. SCHIFF, CDR, MC, USN  
(Specify if M.D., midwife, or other)

Address U.S. Naval Hospital, Annapolis, Md

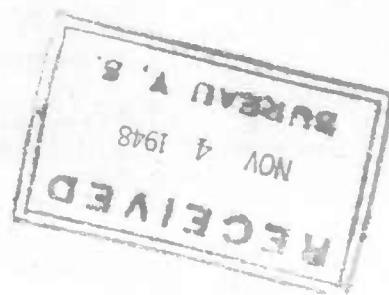
25. (a) Nov. 3, 1948 (b) *John M. Murphy*  
(Date rec'd by registrar) (Signature)26. (To be filled out if no physician was present at delivery.)  
The above certificate has been examined by me.

Health Officer, per

\* See Instruction C on stub.

CHILD LIVED 22 Minutes  
EXPIRED at 9:17 P.M. on 11-2-48

V. S. A10



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Distr. No. 11180 32

## 1. PLACE OF DEATH:

County A.A. City or town Jessups Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? two monthsHospital, Institution, or street address where death occurred: Maryland House of CorrectionHow long in hospital or institution? 49 days.

## 3. (a) FULL NAME

WILLIAM B. GRUBBS.4. Sex M5. Color or race W.6. (a) Single, married, widowed, or divorced Widower6. (b) Name of husband or wife Lena Funk7. Birth date of deceased (mo., day, yr.) Dec 9, 18686. (c) If alive, give age — years8. AGE: 

Years	Months	Days	If less than one day
79	10	22	— hrs. — min.

9. Birthplace Chestnfield Va.  
(Town, county, and state)10. Usual occupation Stonemason11. Industry or business —12. Name Yeowell GRUBBS13. Birthplace Va.14. Maiden name Belle Wool-Richt15. Birthplace Va.16. Informant MHCAddress Jessups Md.17. Removal Removal Date thereof 11-2-48  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory Oakwood CemeteryLocation Richmond Va18. Funeral director Wm. J. Leibner & SonsAddress North & Pennsylvania Baltimore19. M.R. W.M. Date rec'd by registrar 148Address Jessups Md.Registrar Dora Dashin

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A.A.City or town Jessups (If outside city or town limits, write RURAL and give nearest town)Street No. MHC (If rural, give LOCATION)2.(a) If veteran, name war —

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 1<sup>st</sup> 48 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 14 1948 to Nov 1 1948and that I last saw him alive on Nov 1 1948Immediate cause of death Edema of lungsDue to Cirrhosis of LiverDue to —Other conditions —

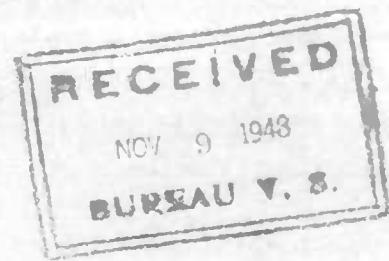
(Include pregnancy within 3 months of death)

Major findings or operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE Wm. A. Clark M.D. M. D. or other —Address Jessups Md. Date signed 11/1/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age  
is especially important. Physicians: please write the causes of death clearly and briefly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11101

157e

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County

HENRY HAMMER

City or town

ANNAPOLIS MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

LIFE

Hospital, institution, or street address where death occurred:

HOME 8 MONROE COURT

How long in hospital or institution?

## 3. (a) FULL NAME

KENNETH LEON HAMMER

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

S

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

15 April 1948

## 6. (c) If alive, give age..... years

## 8. AGE: Years

6

## Months

6

## Days

If less than one day

hrs.

min.

## 9. Birthplace

ANNAPOLIS, MARYLAND

(Town, county, and state)

## 10. Usual occupation.

CHILD

## 11. Industry or business

## MOTHER FATHER

12. Name

Henry Hammer

## 13. Birthplace

Krakow, Poland

## 14. Maiden name

Helen Partner

## 15. Birthplace

Krakow, Poland

## 16. Informant

Henry Hammer

Address

8 Monroe St - ANNAPOLIS, MD

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof. NOV 21/48  
(month) (day) (year)

## Cemetery or crematory

Kensett Israel

## Location

3 miles east

## 18. Funeral director

B. L. Hopkins &amp; Son

## Address

ANNAPOLIS, MD

Nov. 20 1948

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MARYLAND

County

HENRY HAMMER

City or town

ANNAPOLIS, MD

Street No.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

8 Monroe St

County

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

NOVEMBER 19 48 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7 Sept 48 to 19 Nov 48

and that I last saw him alive on 7 Sept 48

## Immediate cause of death

Congestive Heart Disease

## Due to

Disease

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings at operation

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

## Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

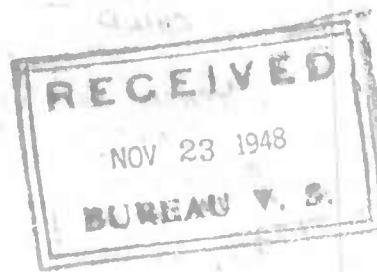
## 23. SIGNATURE

Philip Price M.D.

M. D. or other

Address 2233 Longfellow Rd Date signed

551 X 20  
12-1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11102

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

Anne B.RUNDEL

County 90 Charles St. Annapolis, Md.

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

SAMUEL WESLEY HARDESTY

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

Married

6. (b) Name of husband or wife

Edna WRENN Hardesty

7. Birth date of deceased (mo., day, yr.)

Oct 13 1868

6. (c) If alive, give age 71 years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Calvert Co. Md.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Insurance

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Edna W. Hardesty

Address

90 Charles St. Annapolis Md.

17. Burial

Date thereof Nov 4, 1948

(month)

(day)

(year)

Cemetery or crematory Mt. Zion

Location Lothian Md.

18. Funeral director T. A. Hardesty &amp; Son

Address 412 E. Marlboro, Annapolis

Nov. 3 1948

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Anne Ar.

City or town 90 Charles St. Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

215-18-85928

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1948 al 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1 1948 to Nov 2 1948

and that I last saw him alive on Nov 2 1948

Immediate cause of death

Overt Cardio-Vascular Failure

Due to Coronary Thrombosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Oliver Purvis M. D. or other

Address 11102 Date signed 11/3/48

Registrar



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11103

## CERTIFICATE OF DEATH

28

Reg. Dist. No.

93d

## 1. PLACE OF DEATH:

County

Anne Arundel

City or town

Rural - Odenton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mary Elizabeth Harrison

4. Sex

F

5. Color or race

C w

6. (a) Single, married, widowed, or divorced

Wesley Harrison

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

95

hrs.

min.

6. (c) If alive, give age years

9. Birthplace

Al Co

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Henson

12. Name

13. Birthplace

Al Co

14. Maiden name

Susie Henson

15. Birthplace

Al Co

16. Informant

Eben Shuckett

Address

Odenton Md

17. Burial

Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month)

(day)

(year)

Date

9/14/48

Year

18. Funeral director

W. Gladwin Sons

Address

Bowie

19. (Date rec'd by registrar)

11/13

19

E. Joyce Loran

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Anne Arundel

City or town Rural - Odenton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 12, 1948 at 11:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 10 19

and that I last saw h. alive on

19

Immediate cause of death

Cardiovascular failure

Due to

Atherosclerosis

Due to

Cardiovascular disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE E. Leyton Rittenhouse M.D.

Acting Director

Address Anne Arundel, Md. Date signed 11/14/48

RECEIVED

NOV 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11104

Reg. Dist. No. 28

## CERTIFICATE OF DEATH

1. PLACE OF DEATH:  
Anne Arundel County

County: Crownsville

City or town: (If outside city or town limits, write RURAL and give nearest town)

four days

How long in above place of death?

Hospital, Institution, or street address where death occurred:  
Crownsville State Hospital

four days

How long in hospital or institution?

3. (a) FULL NAME

MARGARET MONICA HENRY

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Negro

Widowed

6. (b) Name of husband or wife

unknown (deceased)

6. (c) If alive, give age — years

7. Birth date of deceased (mo. day, yr.)

December - 1875

8. AGE:

Years  
72Months  
11Days  
?

If less than one day

hrs. .... min.

9. Birthplace

Port Deposit, Maryland

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

MOTHER FATHER

unknown

12. Name

unknown

13. Birthplace

unknown

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Hospital Records

Address

Crownsville State Hospital

17. Burial

Date buried Nov. 24, 1948  
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Jones Memorial Cemetery

Cemetery or crematory

Location Port Deposit Rural, Maryland

18. Funeral director

Joyce A. Patterson &amp; Son

Address

Crownsville, Md.

19. Date rec'd by registrar

19. 88

S. J. Joyce R.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cec. 11

City or town: Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8 Center Street

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1948 at 8:00 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 15, 1948, to November 19, 1948

and that I last saw her alive on November 19, 1948.

Immediate cause of death

Generalized Arteriosclerosis

known to us since 11/15/48

DURATION

Due to

Due to

Other conditions Senile Psychosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

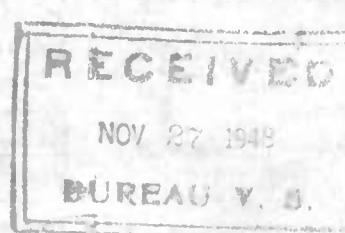
Jacob Worcester M.D.

M. D. or other

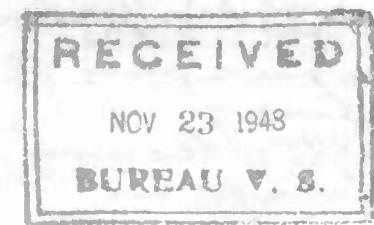
Address: Crownsville, Maryland

Date signed

11/19/48







## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11106

Reg. Dist. No. 21

## CERTIFICATE OF DEATH

47c

1. PLACE OF DEATH:  
 Anne Arundel  
 County.....  
 Eastport  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 15 years  
 Hospital, Institution, or street address where death occurred:.....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Md. County..... A.A.  
 City or town..... Eastport  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 523 State..... St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... World War I

3. (a) FULL NAME Enoch Henry Howes

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced  
 Married  
 Laura Elizabeth Howes

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Aug. 18 1895 8.(c) If alive, give age 45 years

8. AGE: Years 53 Months 3 Days 10 It less than one day hrs. min.

9. Birthplace..... Churchton, Md. (Town, county, and state)

10. Usual occupation..... Elevator OPERATOR OR

11. Industry or business..... US NAVY

MOTHER FATHER  
 12. Name..... John Henry Howes  
 13. Birthplace..... Churchton, Md.

MOTHER  
 14. Maiden name..... Orem  
 15. Birthplace..... Baltimore, Md.

16. Informant..... Mrs. Henry Monsen  
 Address..... 1006 Jackson St, Eastport, Md.

17. Burial..... Date thereof..... Nov. 30, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Woodfields

Location..... Galesville, Md.  
 18. Funeral director..... T.A. Hardisty & Son  
 Address..... Galesville, Md.

19. Nov. 29 1948  
 (Date rec'd by registrar) *J. O. French* *W. Registrar*

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 28 1948 at 12:30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from  
 August 5, 1948 to Nov. 28, 1948  
 and that I last saw him alive on Nov. 28, 1948

Immediate cause of death.....  
 Bronchogenic  
 carcinoma

Due to.....

Due to.....

Other conditions.....  
 Cachexia

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

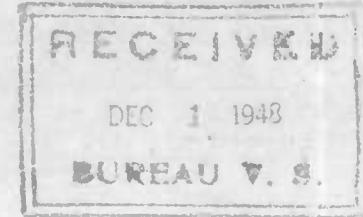
Means of Injury.....

Injured at work?

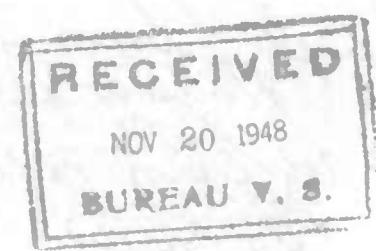
23. SIGNATURE..... *James P. Hartman, M.D.*

M. D. or other

Address..... Galesville, Md. Date signed..... 11/29/48







PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11108

Reg. Diet. No. 21

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County..... Anne Arundel Co.

City or town..... Earleigh Hgts. A. A. Co.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 years

Hospital, institution, or street address where death occurred:

..... at his residences in Earleigh Hgts.

How long in hospital or institution?.....

## 3. (a) FULL NAME

John Jefferies

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Col. Married

6. (b) Name of husband or wife..... Carrie Thomas Jefferies

7. Birth date of deceased (mo., day, yr.)..... January 1881 6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day  
67 11 . . . . . hrs. . . . . min.9. Birthplace..... Blanch N. C. North Carolina  
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business..... None

12. Name..... John Jefferies Sr.

13. Birthplace..... Blanch North Carolina

14. Maiden name..... Esther Pinchbach

15. Birthplace..... North Carolina

16. Informant..... Carrie T. Jefferies

Address..... Earleigh Hgts. Md. R. 1 P. O. Severna Pk.

17. Burial..... Date thereof..... 11-16-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Earleigh Heights, Cemetery

Location..... Earleigh Hgts. A. A. Co. Md.

18. Funeral director..... Mrs Charles E. Hicks

Address..... 45 Northwest St. Annapolis Md.

19. Date rec'd by registrar..... Nov. 15 1948

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel

City or town..... Earleigh Hgts. Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. 1 Severna Park P. O. .

(If rural, give LOCATION)

2. (a) If veteran, name war..... None

## 3. (b) Social Security Number

114-03-6154

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 12 1948 1/20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 25 1948 to Nov 12 1948

and that I last saw him alive on Nov. 10 1948

Immediate cause of death..... Chs. Pulmonary Tuberculosis advanced

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

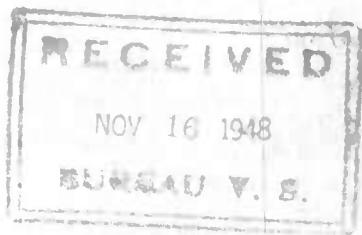
Means of injury.....

Injured at work?

23. SIGNATURE..... M. J. Khawaja

M. D. or other

Address..... Annapolis Md. Date signed..... Nov. 15 1948



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11109

28

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Anne Arundel County

City or town Crownsville State Hospital

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? two years, 10 mos. 17 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? two years, 10 mos. 17 days

## 3. (a) FULL NAME

DANIEL JOHNSON

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

MALE

NEGRO

widowed

## 6. (b) Name of husband or wife

\*\*\*\*\*

## 7. Birth date of deceased (mo., day, yr.)

1890 ?

## 6. (c) If alive, give age

\*\*

years

## 8. AGE:

58 ?

?

?

Years Months Days

It less than one day

hrs.

min.

## 9. Birthplace

Maryland

(Town, county, and state)

## 10. Usual occupation

Laborer

## 11. Industry or business

None

## MOTHER FATHER

## 12. Name

\*\*\*\*

## 13. Birthplace

\*\*\*\*

## 14. Maiden name

Rebecca Johnson

## 15. Birthplace

Maryland

## 16. Informant

Hospital Records

## Address

Crownsville State Hospital

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 12/1/48

Arbutus Memorial PK, Inc

Cemetery or crematory

Md.

## 18. Funeral director

George G. Kelson

## Address

1303 Presstman St.

## 19. December 19 48

(Date rec'd by registrar)

R. W. J. Redman  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County \*\*\*\*

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. none

(If rural, give LOCATION)

2. (a) If veteran, name war. \*\*\*

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH November 28

19 48 21 2:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 11, 1946 1946 to November 28 1948

and that I last saw him alive on Nov. 28 1948

Immediate cause of death Cerebral Arteriosclerosis DURATION

known to us since

Jan. 11

Due to

Due to

Other conditions Senile Psychosis  
Simple Deterioration

(Include pregnancy within 3 months of death)

Major findings of operations \*\*\*\*

Date of op. \*\*\*\*

Autopsy results \*\*\*\*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \*\*\*\*

Date of \*\*\*\*

Where did injury occur? \*\*\*\*

(City or town) \*\*\*\* (State) \*\*\*\*

Injured at home, farm, industry, pub'c place (where?) \*\*\*\*

Injured at work \*\*\*\*

Means of injury \*\*\*\*

Injured at work \*\*\*\*

## 23. SIGNATURE

Joseph Morganster M.D.

M. D. or other

Address Crownsville, Md. Date signed 11/29/48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11110

Reg. Dist. No. 23

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

Anne Arundel

City or town Brooklyn Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

5 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Winifred Johnson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife

Florence Johnson

7. Birth date of deceased (mo., day, yr.)

March 9, 1864

6. (c) If ave., give age..... years

8. AGE:

Years  
84Months  
8Days  
13If less than one day  
hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Stationary Engineer

11. Industry or business

National Distillers

MOTHER FATHER

12. Name

Johnson

13. Birthplace

Dont know

14. Maiden name

Dont know

15. Birthplace

Dont know

16. Informant

Winifred Johnson

Address

201-7 1/2 Ave Brooklyn Pk

17. Burial

Date thereof Nov. 24, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Cedar Hill

Location

C. Winifred Evans

18. Funeral director

J. W. Shultz, Jr.

Address

19. Nov. 23 1948

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Anne Arundel

City or town

Brooklyn Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.

201-7 1/2 Ave

(If rural, give LOCATION)

Mo

2. (a) If veteran, name war

## 3. (b) Social Security Number

8218-09-3258

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 21,

1948

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

May 19, 48 Nov 21, 48

19, 48 10, 19, 48

and that I last saw him alive on Nov. 21, 1948 19, 48

Immediate cause of death

Cerebral

Due to

Hemorrhage

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Meane of injury

Injured at work

23. SIGNATURE

Denis J. McGrath

M. D. (or other)

Address

15 E. Randall Dr.

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death, please write the causes of death clearly and legibly. It is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11111

28

## CERTIFICATE OF DEATH

Reg. Dist. No. 306

## 1. PLACE OF DEATH:

County Anne Arundel County

City or town Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years 15 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 4 years 15 days

## 3. (a) FULL NAME

AMY JONES

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Negro	Married

6. (b) Name of husband or wife

Bennie Jones

\*\*\*

B. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.)

1902

8. AGE: Years	Months	Days	It less than one day
46	--	--	hrs. min.

9. Birthplace Virginia

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business none

12. Name Billy Hollaman

13. Birthplace Virginia

14. Maiden name \*\*\*\*\*

15. Birthplace Virginia

16. Informant Hospital Records

Address Crownsville State Hospital

17. Burial (Burial, cremation, or removal, where) Date thereof 1/10/48

(month) (day) (year)

Cemetery or place of removal \*\*\*\*\*

Location Crownsville Md

18. Funeral director Ralph Hospital

Address Crownsville Md

19. (Date rec'd by registrar) 1/10/48 E. J. Joyce, Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County \_\_\_\_\_

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 112 W. 23rd Street

(If rural, give LOCATION)

2.(a) If veteran, name war. \*\*\*

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

November 28, 1948

9:40PM

20. DATE OF DEATH November 13, 1944, to Nov. 28

148

and that I last saw her alive on Nov. 28

19. 48

Immediate cause of death General Paresis

11/13/44

Due to:

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations \*\*\*

Date of op. \*\*\*

Autopsy results \*\*\*

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \*\*\*

Date of \*\*\*

Where did injury occur? \*\*\*

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \*\*\*

Means of injury \*\*\*

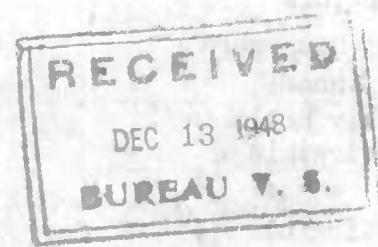
Injured at work? \*\*\*

23. SIGNATURE

Crownsville, Md.

M. D. or other

Date signed 11/29/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11112

28

## CERTIFICATE OF DEATH

99  
Reg. Diat. No.

## 1. PLACE OF DEATH:

County Anne Arundel

Crownsville

City or town.

(If outside city or town limits, write RURAL and give nearest town)

21 years

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Crownsville State Hospital

How long in hospital or institution?.. 21 years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Washington, D.C.

State

County

City or town Washington, (Little Sisters of the Poor)

(If outside city or town limits, write RURAL and give nearest town)

Street No. H &amp; 3rd Sts., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## 3. (a) FULL NAME

EDWARD JONES (ALIAS JERRY)

4. Sex Male 5. Color or race Negro 6.(a)Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Unknown - About 1888

8. AGE: Years Months Days It less than one day  
60?                     hrs.      min.9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Thomas Jones

13. Birthplace Maryland

14. Maiden name Sophie Lee

15. Birthplace Maryland

16. Informant Hospital Records

Address Crownsville, Maryland

17. Burial Date thereof 11/18-48  
(Burial, inhumation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hospital

Location Crownsville, Md.

18. Funeral director Sup'r.

Address Crownsville, Md.

19. 11/18 1948

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1948 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 11, 1948 to November 11, 1948 and that I last saw him alive on November 11, 1948

Immediate cause of death

Generalized Arteriosclerosis  
Known to us since

Due to

Due to

Other conditions Psychosis with Mental  
Deficiency known to us since  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results - pp -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

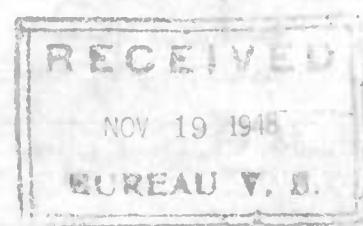
23. SIGNATURE

Jacob Thompson, M.D.

M. D. or other

Address

Crownsville, Md. Date signed 11/11/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

11113

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Bertha E. Blakring

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife

Leslie S. Blakring

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

Sept 30<sup>th</sup> 1884

8. AGE:

Years

Months

Days

If less than one day

64

1

7

.hrs. min.

9. Birthplace

(Town, county, and state)

Annapolis Md.

10. Usual occupation

House wife

11. Industry or business

Thomas Basil

MOTHER FATHER

12. Name

Annapolis Md.

13. Birthplace

Mary C. Basil

14. Maiden name

Annapolis Md.

15. Birthplace

Leslie S. Blakring

16. Informant

Burial

1090 Lafayette Ave Annapolis Md.

17. Cemetery or crematory

Date thereof

Nov. 11-7-9-48

(month)

(day) (year)

(Burial, cremation, or removal. Which?)

Location

Naval Academy

18. Funeral director

John M. Gay Co. Son

Address

Annapolis Md.

19. (Date rec'd by registrar)

Nov. 9 48

19

W Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 7

19 48 at 6 7 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1

19 48

to

Nov 7

19 48

and that I last saw her alive on

Nov 6

19 48

Immediate cause of death

Myocarditis & myocardial  
Insufficiency C.M.

DURATION

Due to

Hyperthyroidism

Unknown

Due to

Sickle cell

years

Other conditions

Ch. Intestinal defects

Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George E. Basil

M. D. or other

Address

Annapolis Md.

Date signed 11-8-48

RECEIVED

NOV 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11114

21

## CERTIFICATE OF DEATH

Reg. Dist. No. 108

## 1. PLACE OF DEATH:

County Anne Arundel

City or town Severn

(If outside city or town limits, write RURAL and give name of town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Pauline Augusta Lehner

## 4. Sex

F.

## 5. Color or race

W.

## 6.(a) Single, married, widowed, or divorced

married

## 6.(b) Name of husband or wife

August J. Lehner

(6.c) Alive, give age 68 years

## 7. Birth date of deceased (mo., day, yr.)

April 7, 1880

## 8. AGE:

Years 68

Months 7

Days 13

If less than one day

hrs. .... min.

## 9. Birthplace

Baltimore, Md.

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

FATHER 12. Name John A. Fox

MOTHER 13. Birthplace Baltimore, Md.

14. Maiden name Christine Zeun

15. Birthplace Germany

16. Informant Mr. August Lehner

Address Severn P. O., Md.

17. Burial Date thereof 11/23/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Glen Haven Cem.

Location Glen Burnie, Md.

18. Funeral director WM. J. TICKNER &amp; SONS

Address Balto., Md.

19. Nov. 22, 1948 (Date rec'd by registrar)

A. W. Redmond  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborns, state giving residence of mother)

State

Md. Anne Arundel

County

City or town

Severn

Street No.

Telegraph Road

(If rural, give location)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

Nov 20 - 48

1948 at 7 P.M.

and that I last saw her alive on Nov 19 - 1948

## Immediate cause of death

Total Premature

## DURATION

1 day

## Due to

## Due to

## Other conditions

Gastric - Cerebral thrombosis

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

J. W. Redmond M.D. or other

Address 108

Date signed Nov 20 - 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11115

21

Reg. Dist. No.

## CERTIFICATE OF DEATH

1310

## 1. PLACE OF DEATH

County

A. A. S.

City or town

Jacobsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

A. A. S.

City or town

Jacobsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Fort Smallwood Rd. Suite #3

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## 3. (a) FULL NAME

John Bruce Mackenzie

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

White Divorced.

6.(b) Name of husband or wife

Annie M. Mackenzie

6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.)

Sept 3, 1872

8. AGE:

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Barker, Retired.

11. Industry or business

MOTHER FATHER

12. Name

?

13. Birthplace

?

14. Maiden name

?

15. Birthplace

?

16. Informant

Harry C. MacKenzie.

Address

Fort Smallwood Rd.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov 26, 1948

(month)

(day)

(year)

Cemetery or crematory

A. M. Ridge.

Location

Pikemville

18. Funeral director

Paul C. Lehman Jr.

Address

3615-17 Chestnut Ave.

19. Date rec'd by registrar

Nov. 24, 1948

R. W. H. Davis

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1948 about

not attended deceased from d. i. d.  
did not see him alive on

and that I last saw him alive on

Immediate cause of death Myocardial  
failure - acute

DURATION

Due to Hypertensive cardio-vascular 1yr  
Disease, Chronic Glomerulo-nephritis 6mos

Due to Generalized arterio-sclerosis 10d. nite

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

M. D. or other

Address Green Gables-Pasadena, Md.

Date signed 11/23/48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11116

## CERTIFICATE OF DEATH

93d  
Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County.....

Hanover, Md.

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

3 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Agnes A. Makinson

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

single

7. (b) Name of husband or wife.....

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Oct. 24, 1873

8. AGE: Years Months Days If less than one day  
75 0 20 hrs. min.

9. Birthplace.....

(Town, county, and state)

None

10. Usual occupation.....

11. Industry or business.....

12. Name..... Daniel Makinson

13. Birthplace..... Baltimore, Md.

14. Maiden name..... Caroline Johanes

15. Birthplace..... Baltimore, Md.

16. Informant..... Mrs. Roland R. Ray

Address..... Harmons, Md.

17. Burial.....

(Burial, cremation, or removal: Which?) Date thereof.....

11/17/48

Cemetery or crematory..... Western Cem.

Location..... Balto., Md.

18. Funeral director..... WM. J. TICKNER &amp; SONS

Address..... Balto., Md.

19. (Date tested by registrar) 11/15

x

A. W. Hedrick

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County.....

Hanover

City or town..... Hanover

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name was.....

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Nov. 14

19

48

Nov. 14 1948

10

48

and that I last saw her alive on Nov. 13 1948

10

48

IMMEDIATE CAUSE OF DEATH

coronary thrombosis -

DURATION

first

Due to hypertension cardio -

3 yrs.

vascular disease -

?

arterio-sclerosis -

5 days.

Other conditions Hepatitis -

(Include pregnancy within 8 months of death)

## MAJOR FINDINGS OF OPERATIONS

Date of op.

## AUTOPSY RESULTS

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## MEANS OF INJURY

Injured at work?

## 23. SIGNATURE

M. D. or other

Address..... Savage, Md. Date signed 11/14/48

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registers, etc.

MARGIN RESERVED FOR BINDING

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Anne Arundel

(c) City or town Deale  
(If outside city or town limits, write RURAL and give town)

(d) Street No. \_\_\_\_\_  
(If rural give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country. \_\_\_\_\_

## MANIFOLD

## **MEDICAL CERTIFICATION**

20. DATE OF DEATH November 14 1948, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy ..... thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... his death on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined  and that the causes of death were:

**IMMEDIATE CAUSE OF DEATH.**

Cerebral edema  
due to acute alcoholism.

Due to...

### Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary  or contributing  cause of death, fill in the following:

(a) Date of injury..... at..... M.

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury.....

23. Signature \_\_\_\_\_ M.D.  
Date signed 11-15-48 Medical Examiner

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11117

## CERTIFICATE OF DEATH

164C  
Reg. Dist. No. 27

## 1. PLACE OF DEATH:

County Anne Arundel

City or town Fort George G Meade

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Dead on arrival

## 3. (a) FULL NAME

ROBERT J. MASON

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

29 July 1920

## 8. AGE:

28

## Years

Months

## Days

If less than one day

.....hrs. .....min.

## 9. Birthplace

Boston, Massachusetts

(Town, county, and state)

## 10. Usual occupation

Soldier

## 11. Industry or business

12. Name R. Page Mason

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

## 16. Information

Service Records

Address U.S. Army

17. Removal Date thereof 12 November 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Unknown

Location Philadelphia, Pa.

18. Funeral director Lilly &amp; Zeiler Inc

Address Baltimore, Maryland

19. 12 Nov 48 JAMES N. GOERGER, Capt.

(Date rec'd by registrar) M.S.C. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County

City or town Philadelphia

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

12 November 1948 at 1650 hrs

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from viewed the deceased

and that I last saw him alive on 12 November 1948

Immediate cause of death Wound, penetrating

gunshot, .45 cal., point of entrance Instant

3d interspace, left anterior chest

1/1/7 cm from mid sternal bone

Due to hemorrhage into left pleural cavity

Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

None

Date of op.

Autopsy results SEE REVERSE SIDE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 11/12/48

Where did injury occur? FT. MEADE Q.R. Ind.

(City or town)

(County) (State)

Injured at home, farm, industry, public place (where?) ARMY Post

Means of injury Gunshot wound Injured at work? No

David R. Metcalf, Capt. M.C.

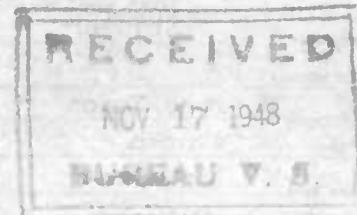
23. SIGNATURE DAVID R METCALF, Capt., M.C.

Ft. Meade, Md. M. D. or other

Address Date signed 15 Nov 48

AUTOPSY RESULTS:

MISSILE TRACT TRAVERSING LEFT ANTERIOR CHEST WALL,  
LEFT PLEURA, PERICARDIUM, LEFT VENTRICLE OF HEART,  
LEFT LUNG AND LEFT POSTERIOR CHEST WALL.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11118

Reg. Dist. No. 21

## CERTIFICATE OF DEATH

173

1. PLACE OF DEATH:  
Anne Arundel  
County  
City or town South Down Lake Nr. Annapolis  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Anne Arundel  
City or town Eastport, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1208 Bay Ridge Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war W.W. II

## 3. (a) FULL NAME

CHARLES HENRI MASTERS

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced		
Male	White	Married		
6. (b) Name of husband or wife Dorita Watson Masters				
6. (c) If alive, give age 23 years				
7. Birth date of deceased (mo., day, yr.) June 19, 1921				
8. AGE:	Years	Months	Days	If less than one day
	27	4	26	hrs. min.
9. Birthplace Eastport A.A. Co., Maryland (Town, county, and state)				
10. Usual occupation Inspector				
11. Industry or business Tidewater Fisheries Commission St. of Maryland				
MOTHER FATHER	12. Name	Dr. George Taylor Masters		
	13. Birthplace	La.		
14. Maiden name Henrietta Windsor				
15. Birthplace Annapolis, Maryland				
16. Informant George W. Masters (Brother)				
Address 1208 Bay Ridge Ave. Eastport, Md.				
17. Burial Date thereof 11-18-48 (Burial, cremation, or removal. Which?) (month) (day) (year)				
Cemetery or crematory Cedar Bluff Cemetery				
Location Annapolis, Maryland				
18. Funeral director Ben L. Hopping and Son				
Address 170-172 West St. Annapolis, Maryland				
19. Nov 17 1948 (Date rec'd by registrar) <i>John M. Caffey, M.D.</i> Signature <i>John M. Caffey, M.D.</i> Address <i>Annapolis, Md.</i> Date signed <i>11-17-48</i>				

3. (b) Social Security Number 216-16-4028

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1948 2-30 p.m.

21. I CERTIFY that death occurred on the date above stated: *Postmortem Examination* Nov. 15, 1948

Immediate cause of death Fracture of skull  
Hemorrhage

Due to: *Right ankle almost completely severed at joint*

Due to: *Right ankle almost completely severed at joint*

Other conditions: *(Include pregnancy within 8 months of death)*

Major findings of operations: *None*

Date of op. *None*

Autopsy results: *None*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: *accident* Date of *Nov. 15, 1948*

Accident, suicide, or homicide: *accident* Date of *Nov. 15, 1948*

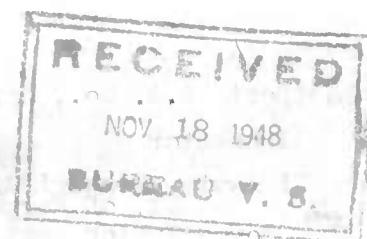
Where did injury occur? *near house A.A. Maryland* City, town *near house* County *A.A. Maryland* State *Md.*

Injured at home, farm, industry, public place (where?) *near house* *near house* *South River*

Means of injury *air plane crash* Injured at work? *Yes*

*John M. Caffey, M.D.* *debut medical examination* M. D. or other *John M. Caffey, M.D.* Date signed *11-17-48*

23. SIGNATURES  
Address *Annapolis, Md.*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

11119

23

Reg. Dist. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

9 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Edward T. Mitchell

4. Sex

Male

5. Color or race

negro

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Virginia Mitchell

7. Birth date of deceased (mo., day, yr.)

Feb. 12 1908

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Cedar Hill, Brooklyn, A.A.C., Md.

(Town, county, and state)

10. Usual occupation

Warehouse Foreman

11. Industry or business

Ordnance U. S. Army

MOTHER FATHER

12. Name

Edward T. Mitchell

13. Birthplace

North Carolina

14. Maiden name

Margery L. Williams

15. Birthplace

Adar Hill, A.A.C., Maryland

16. Informant

Margery L. Mitchell

Address

308 Cedar Hill Lane, Baltimore 25 Md.

17. Burial

Date thereof

12-1-48

(Burial, cremation, or removal, Which?)

(month)

(day)

(year)

Cemetery or crematory

Mount Calvary Cem.

Location

A. A. Co.

18. Funeral director

Charles R. Law

Address

802 Madison Ave.

19. Nov. 29 1948

A. W. Frederick

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Virginia

County

City or town

Alexandria

(If outside city or town limits, write RURAL and give nearest town)

Street No.

207 No. Payne

(If rural, give LOCATION)

2. (a) If veteran, name war

World War II

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 27

1948

at 8<sup>30</sup> p.m.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Roxbury Examinator 1948

and that I last saw him alive on Nov. 27, 1948

Immediate cause of death

Acute dilation of Heart

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mssns of injury

Injured at work?

23. SIGNATURE

John M. Laffy M.D. *deputy medical examiner*

Address: Baltimore, Md. M. D. or other

Date signed

Evidence for change of  
age shown on:

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11120

21

Reg. Dist. No.

## FILM No. G 110 DEC - 8 1948 CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

Anne Arundel

County

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? DOA

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution? DOA

## 3. (a) FULL NAME

JOSEPH HENRY NOTHEY

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Carrie L. Nothey

6. (c) If alive, give age 37 years

## 7. Birth date of deceased (mo. day, yr.)

August 3, 1916

## 8. AGE:

32

33

3

Months

Years

Days

If less than one day

hrs.

min.

## 9. Birthplace

Leeland, Maryland

(Town, county, and state)

## 10. Usual occupation

Car Salesman

## 11. Industry or business

Automobile

## MOTHER FATHER

## 12. Name

James H. Nothey

## 13. Birthplace

Maryland

## 14. Maiden name

Rose Mary Bell

## 15. Birthplace

Maryland

## 16. Informant

Mrs. Carrie L. Nothey

## Address

RFD #1 Riva Rd Annapolis, Maryland

## 17. Burial

Date thereof Dec 2, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Baltimore National

## Location

Baltimore, Maryland

## 18. Funeral director

Ben L. Hopping and Son

## Address

170-172 West St. Annapolis, Maryland

Nov. 30 1948

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Anne Arundel

City or town

Rural

nr Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.

RFD #1

(If rural, give LOCATION)

2.(a) If veteran, name war

WW II

## 3. (b) Social Security Number

578-12-8634

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Nov. 29, 1948 4:05 PM

21. I CERTIFY that death occurred on the date above stated. *Post mortem Examiner**at the last known residence* *Nov. 29, 1948.*

## Immediate cause of death

*Hemorrhage from lungs sudden*

## Due to

*Pulmonary tuberculosis anterior*

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings or operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

## Where did injury occur

(City or town)

(County)

(State)

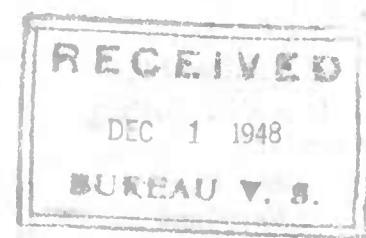
Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

*John M. Claffey M.D. Medical Examiner  
Annapolis, MD. M.D. or other  
Date signed 11-29-48*



PLEASE WRITE PLAINLY, WITH UNFADEING INK. Supply every item of information carefully and concisely. Physicians: please write the causes of death clearly and definitely.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11121

## CERTIFICATE OF DEATH

182  
Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County

City or town

Anne Arundel

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

dead on arrival

Hospital, Institution, or street address where death occurred:

Annapolis Hospital

dead on arrival

How long in hospital or institution?

## 3. (a) FULL NAME

Linda Louise Parks

## 3. (b) Social Security Number

## 4. Sex

female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

—

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

Sept. 9, 1948

## 6. (c) If alive, give age years

## 8. AGE:

Years

2

Months

5

Days

If less than one day

hrs.

min.

## 9. Birthplace

(Town, county, and state)

Annapolis, A.A.P., Maryland

## 10. Usual occupation

## 11. Industry or business

MOTHER FATHER

Garland Parks

## 12. Name

Sugar Grove, Va

## 13. Birthplace

Mildred Candell

## 14. Maiden name

Virginia

## 15. Birthplace

Garland Parks

## 16. Informant

Garland Parks

## Address

Gambrills, Md.

## 17. Removal

(Burial, cremation, or removal. Which?)

Date thereof November 15, 48

(month) (day) (year)

## Cemetery or crematory

Location Rural Retreat, Virginia

## 18. Funeral director

Ben L. Hopping and Son

## Address

170-172 West St. Annapolis, Maryland

## 19. Nov. 15, 48

(Date rec'd by registrar)

M.J. Drury

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Anne Arundel

City or town

Gambrills

P.O.

Street No.

near Prince's Bridge

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Nov. 14, 48, at 10<sup>00</sup> M

## 21. I CERTIFY that death occurred on the date above stated

Postmortem Examination

Nov. 14, 1948

## Immediate cause of death

Suffocation

## Due to

Accidental

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

accident Nov. 14, 1948

## Where did injury occur?

Gambrills P.T.A. Md

(City or town)

(County) (State)

Injured at home, farm, industry, public place (where?)

at home

## Means of injury

asphyxiation

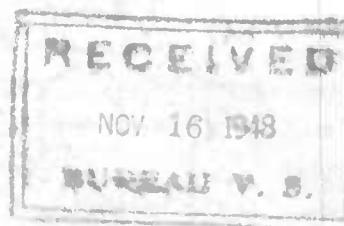
injured at work

## 23. SIGNATURE

John M. Flaherty M.D. medical examiner

M. D. or other

Annapolis, Md. Date signed 11-14-48



8A.27

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct and especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11122

Reg. Dist. No. 21

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County..... Anne Arundel  
 City or town..... Severn, Md., R.F.D. Box 171D  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 20 years

Hospital, institution, or street address where death occurred:

Stevenson's Road

How long in hospital or institution?.....

## 3. (a) FULL NAME

Morris Richard Parrish

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... March 1, 1897  
 (b) If alive, give age..... years

8. AGE: Year..... 51 Months..... 8 Days..... 4  
 If less than one day..... hrs..... min.

9. Birthplace..... Scaggsville, Howard Co., Md.

(Town, county, and state)

10. Usual occupation..... Millworker (ret.)

## 11. Industry or business

12. Name..... Morris Stanley Parrish

13. Birthplace..... Dickiesville, Howard Co., Md.

14. Maiden name..... Anna Day

15. Birthplace..... Howard Co., Md.

16. Informant..... Mrs. Clara Parrish

Address..... Severn, Md., R.F.D. BOX 171D

17. Burial..... Nov. 6, 1948  
 (Burial, cremation, or removal. Which?)

Date thereof..... (month) (day) (year)

Cemetery or crematory..... Glen Haven

Location..... Glen Burnie

18. Funeral director..... Thomas W. Singleton

Address..... Glen Burnie, Maryland

19. Nov. 6, 1948  
 (Date rec'd by registrar)L. J. D. Allen  
 Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel  
 City or town..... Severn, Md., R.F.D. Box 171D  
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... Stevenson's Road  
 (If rural, give LOCATION)

## 2. (a) If veteran, name war.....

## 3. (b) Social Security Number

213-20-6528

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 4, 1948, at 4:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death..... C. A. RONARY THROMBOSIS

DURATION

Due to..... ARTERIOSCLEROSIS

Due to..... UNKNOWN.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

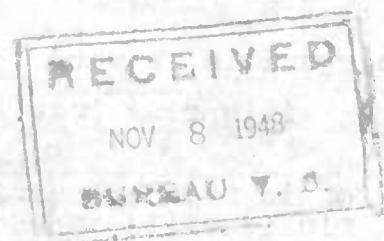
Means of injury

Injured at work?

23. SIGNATURE..... Henry F. Zangara, M.D.

M. D. or other

Address..... Glen Burnie, Md. Date signed..... 11/5/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11123

## CERTIFICATE OF DEATH

159  
Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County.....

City or town.....

Anne Arundel  
Anne Arundel Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital Annapolis

How long in hospital or institution?

## 3. (a) FULL NAME

ALBERT

James A. Poland.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M.

W.

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo. day, yr.)

NOV 13 1948

6. (c) If alive, give age.....years

8. AGE:

Years      Months      Days      If less than one day

2      hrs.      min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Nov. 16 1948

(Date rec'd by registrar)

Date thereof A.D. 1948  
(month) (day) (year)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

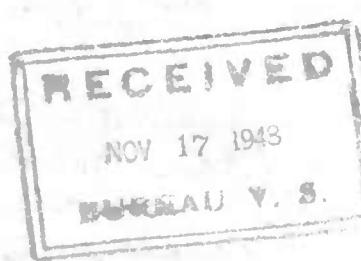
City or town.....

Street No.....

County.....

Md.

Sudley



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11124

20

## CERTIFICATE OF DEATH

1226  
Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County... Anne Arundel

City or town... Rural Hanwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

George Albert Randall

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

colored

widow

6. (b) Name of husband or wife....

Alice Randall

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

may 26, 1862

8. AGE: Year

Months

Days

If less than one day

86

5

9

hre.

min.

9. Birthplace....

A.A. Co. Hanwood, Md.

(Town, county, and state)

10. Usual occupation....

Farmer

11. Industry or business....

Stephen Randall

MOTHER

FATHER

12. Name....

13. Birthplace....

14. Maiden name....

15. Birthplace....

Synthas Jones.

Address....

Hanwood, Md.

17. Burial....

(Burial, cremation, or removal. Which?)

Date thereof... nov. 7 1948  
(month) (day) (year)

Cemetery or crematory....

Chews Chapel

Location....

Hanwood, Md.

18. Funeral director....

J. B. Johnson

Address....

34 Lafayette Ave. Baltimore, Md.

19. Nov. 7, 1948

(Date rec'd by registrar)

M.R. Clancy

ay 1948 Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Anne Arundel

City or town... Hanwood, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH... November 4, 1948, at 4:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 3, 1948, to Nov. 4, 1948

and that I last saw him.... alive on....

Immediate cause of death....

Paroxysmal Op. Traction

DURATION

Due to....

Due to....

Other conditions....

(Include pregnancy within 3 months of death)

Major findings of operations....

Date of op....

Autopsy results....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.... Date of....

Where did injury occur?.... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury....

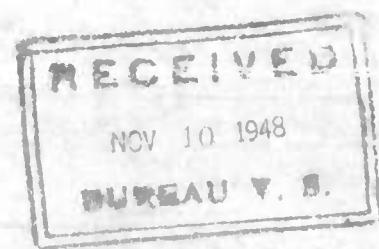
Injured at work?

23. SIGNATURE....

10 Carroll M. D. or other

Date signed 11-6-48

Address....



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11125

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County: Glen Burnie  
City or town: (If outside city or town limits, write RURAL, and give nearest town)

How long in above place of death?

4 years

Hospital, institution, or street address where death occurred:

Oakwood Road

How long in hospital or institution?

## 3. (a) FULL NAME

Sallie Eakin RIPLEY

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.

W.

Widow.

## 6. (b) Name of husband or wife

Isaac C. RIPLEY  
(dead)

6. (c) If alive, give age, years

## 7. Birth date of deceased (mo. day. yr.)

January 9-1879

## 8. AGE:

Years  
69Months  
9Days  
22

If less than one day

hrs.

min.

## 9. Birthplace

Craig County - Virginia  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

John Eakin

## 12. Name

Virginia

## 13. Birthplace

Callevell

## 14. Maiden name

Callevell

## 15. Birthplace

Virginia

## 16. Informant

Miss Pauline RIPLEY (daughter)

## Address

Glen Burnie, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 3, 1948

(month) (day) (year)

## Cemetery or crematory

Woodlawn

## Location

Baltimore

## 18. Funeral director

Thomas W. Singleton

## Address

Glen Burnie, Md.

## 19. (Date rec'd by registrar)

1948

10/28

M  
Margin Reserved for Binding

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County D. A.

City or town S. Luthersum (If outside city or town limits, write RURAL and give nearest town)

Street No. Hampton Road (If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

November 1, 1948, at 10<sup>45</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

Coronary Occlusion DURATION Sudden

Due to arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

## 23. SIGNATURE

M. D. or other

Address Glen Burnie, Md. Date signed



10 M  
Age  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11126

21

Reg. Dist. No. ....

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

Anne Arundel

City or town

Anne Arundel Park, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

36 days

(If outside city or town limits, write RURAL and give nearest town)

Hospital, institution, or street address where death occurred:

Cedar Crest Nursing Home

How long in hospital or institution?

## 3. (a) FULL NAME

Eva K. Ritt

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F. W. Married

6. (b) Name of husband or wife

Eugene Ritt

7. Birth date of deceased (mo. day, yr.)

October 9 - 1881

6. (c) If alive, give age

68 years

6. (c) If alive, give age

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

11127  
28

1. PLACE OF DEATH: Anne Arundel  
 County Crownsville  
 City or town. (If outside city or town limits, write RURAL and give nearest town) Crownsville  
 How long in above place of death? 3 mos. 12 days  
 Hospital, Institution, or street address where death occurred: Crownsville State Hospital  
 How long in hospital or institution? 3 mos. 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 Maryland  
 State Baltimore  
 City or town. (If outside city or town limits, write RURAL and give nearest town) Baltimore  
 Street No. 1731 Ashland Avenue  
 (If rural, give LOCATION)

3. (a) FULL NAME  
 EDWARD SANDERS

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife  
 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 55 Months Days If less than one day hrs. min.

9. Birthplace South Carolina  
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER 12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant Hospital Records

Address Crownsville, Md.

17. Burial Date thereof 11/15-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery Cemetery Hospital

Location Crownsville Md.

18. Funeral director Dr. J. Hospital

Address Crownsville Md.

19. (Date rec'd by registrar) 11/15-48 E. Joyce F. F. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1948 at 4:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 1948 to November 10 1948 and that I last saw him alive on November 10 1948

Immediate cause of death General Arteriosclerosis known to us since 7/29/48 DURATION

Due to.

Due to.

Other conditions Psychosis with Cerebral

Arteriosclerosis - known to us since 9/29/48  
 (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'l place (where?)

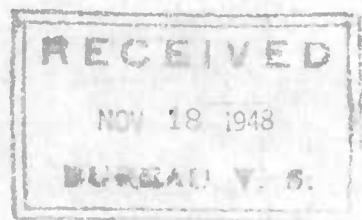
Means of injury Injured at work?

23. SIGNATURE M. D. or other

Address Crownsville, Md. Date signed 11/10/48

MARGIN RESERVED FOR BINDING

VS. A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MD. STATE  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 23

1. PLACE OF DEATH:  
(a) Baltimore City, Maryland  
(b) Street address Monroe Circle, Glen Burnie  
(c) Hospital or institution:  
  
(d) Length of stay in hospital or inst. (yrs., mos., or days)  
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Glen Burnie  
(c) City or town (If outside city or town limits, write RURAL and give town)  
(d) Street No. 106 4th Avenue (If rural give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country.

3 (a) FULL NAME

HARRY WOOD

SHELL

3 (b) If veteran, name war  
None 3 (c) Social Security Account  
No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or  
divorced. Married

6 (b) Name of husband or wife Margaret Virginia Shell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1903

8. AGE: Years Months Days If less than one day  
45 4 21 hr. min.

9. Birthplace South Carolina  
(Town, county, and state)

10. Usual Occupation Boiler Engineer

11. Industry or business Consol. Gas. & Elec. Co.

MOTHER FATHER  
12. Name Harry Shell  
13. Birthplace South Carolina

14. Maiden Name ?  
15. Birthplace ?

16 (a) Informant Mrs Margaret V. Shell  
(b) Address 106 - 4th Ave. South, Glenburnie

17 (a) Burial (b) Date thereof 11-19-48  
(Burial, cremation, or removal) (month) (day) (year)  
(c) Cemetery or crematory Glen Haven Cem.  
Location A. A. Co. Md.

18 (a) Funeral director Wm. J. Tickner & Sons  
(b) Address Baltimore, Maryland

19 (a) 11-18-48 (b) (Date rec'd by registrar)  
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1948, at 5:25 P.M.

21. I certify that I took charge of the remains described above, held an Insp & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes  accident , suicide , homicide , undetermined  and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary  or contributing  cause of death, fill in the following:

(a) Date of injury ..... M.  
(b) Where did injury occur?  
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?

(d) Means of injury

23. Signature Earl R. Roy M.D.  
Date signed 11-17-48  
Medical Examiner

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11129

20

## CERTIFICATE OF DEATH

47a  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

Male | White | Married

6. (b) Name of husband or wife..... Eva Gertrude Sherket

7. Birth date of deceased (mo. day, yr.) Sept 26, 1885

6. (c) If alive, give age..... years

8. AGE: Years..... 63 Months..... 1 Days..... 14 If less than one day  
hrs..... min.....9. Birthplace..... Mc Kendree, Cal. Co., Md  
(Town, county, and state)

10. Usual occupation..... Carpenter

11. Industry or business.....

12. Name..... John W. Sherket

13. Birthplace..... Tracy Ldg, Md

14. Maiden name..... Anna Crosby

15. Birthplace..... Park

16. Informant..... Alice S. Wayson

Address..... Jewell, Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof..... Nov. 14, 1948

(month) (day) (year)

Cemetery or crematory..... Mt. Zion

Location..... Lothian O. C. C., Md.

18. Funeral director..... Ritchie Bros.

Address..... Upper Marlboro, Md

19. (Date recd by registrar) 19..... 19..... 19..... 19.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... St. G

City or town..... Rural-Bristol, Md  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 2 mi. East -  
(If rural, give LOCATION)

2.(a) If veteran, name war..... No.

## 3. (b) Social Security Number

212-16-8312

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... 11 November 1948 at 5:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

30 October 1948, to 11 Nov 1948

and that I last saw h. l. m. alive on 11 Nov 1948

Immediate cause of death..... Arrembury Colitis

DURATION..... 2 hrs

Due to..... Caseous, left lung

1 1/2 yrs

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Inoperable carcinoma

Date of op. 22-Sept-48

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... R. J. James, M.D.

M. D. or other

Address..... Upper Marlboro, Md Date signed 11/14/48

RECEIVED

NOV 15 1948

FEDERAL BUREAU OF INVESTIGATION

1100 30th St. N.W. 20535

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11130

Reg. Dist. No. 21

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Anne Arundel

City or town Severna Park - R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Cedar Crest Nursing Home

How long in hospital or institution?

## 3. (a) FULL NAME

VIRGINIA C. STEVENSON

## 4. Sex

F

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Com. Charles W. Stevenson

## 8. (c) If alive, give age..... years

65

## 7. Birth date of deceased (mo. day. yr.)

June 8, 1879

## 8. AGE:

Years  
69Months  
4Days  
12

If less than one day

hrs. min.

## 9. Birthplace

New York, N.Y.

(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

## MOTHER FATHER

12. Name Andrew Canfield

13. Birthplace New York, N.Y.

## 14. Maiden name

Emily Groce

## 15. Birthplace

Philadelphia, Pa.

## 16. Informant

Mrs. T. I. Terrant

## Address

2915 Connecticut Ave., Wash., D.C.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 23, 1948

(month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

## 18. Funeral director

Thomas W. Singleton

Address Glen Burnie, Maryland

Nov 22

(Date rec'd by registrar) 1948

L. Jordan

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Gambrills

(If outside city or town limits, write RURAL and give nearest town)

Street No. Miller'sville Ft. Meade Road

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

November 20 1948, at 2:47 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

September 1946, to Nov. 20 1948

and that I last saw her alive on Nov 19 1948

## Immediate cause of death

Multiple Sclerosis

DURATION

10 years

## Due to

## Due to

Other conditions Diabetes Mellitus

10 years

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

Edward J. O'Herlihy, M.D.

M. D. or other

Address Gambrills Md. Date signed Nov 22, 1948



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

9402

11131

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... Anne Arundel  
 City or town..... Glen Burnie  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Years

Hospital, Institution, or street address where death occurred:

438 N. Crain Highway

How long in hospital or institution?.....

## 3. (a) FULL NAME

Charles F. Strickland

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife..... Edna M. Strickland  
 (Nee Lowman)

(6. c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) January 8, 1903

8. AGE: Years Months Days If less than one day  
 45 10 4 hrs. min.9. Birthplace..... Baltimore (Pimlico) Md.  
 (Town, county, and state)

10. Usual occupation..... Conductor

11. Industry or business..... Baltimore &amp; Ohio Railroad.

12. Name..... William Richard Strickland

13. Birthplace..... Maryland

14. Maiden name..... Emily Stienaker

15. Birthplace..... Maryland

16. Informant..... Mrs. Edna Strickland

Address..... 438-2nd Ave. N.W. Glen Burnie, Md.

## 17. Burial

(Burial, cremation, or removal. Which?) Date thereof Nov. 16, 1948

(month) (day) (year)

Cemetery or crematory..... Glen Haven Cemetery

Location..... Glen Burnie, Md.

18. Funeral director..... Thomas W. Singleton

Address..... Glen Burnie, Md.

19. Date rec'd by registrar..... Nov. 15, 1948

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel

City or town..... Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 438 Crain Highway N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

705 10 0807

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Nov. 12, 1948 8 p.m.

21. I CERTIFY that death occurred on the date above stated: Post mortem Examination  
accident Nov. 12, 1948

## Immediate cause of death.....

Dysrhythmia sudden

## Due to.....

Coronary sclerosis

## Other conditions.....

(Include pregnancy within 3 months of death)

## Major findings of operations.....

Date of op.

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury.....

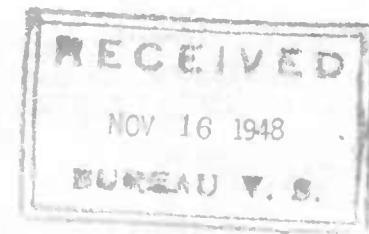
Injured at work? Depot  
John A. Coffey M.D. Medical  
Examiner

## 23. SIGNATURE

M. D. or other

Address..... Baltimore, Md.

Date signed..... Nov. 12, 1948



1  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11132

93d  
Reg. Dist. No. 21

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Anne Arundel  
City or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Mr. Carl L. Swenson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Catherine A. Swenson

7. Birth date of deceased (mo., day, yr.)

June 8, 1885

6. (c) If alive, give age

years

8. AGE:

Years	Months	Days	11 less than one day
63	5	12	hrs. min.

9. Birthplace

Wisconsin

(Town, county, and state)

10. Usual occupation

Pipe fitter U. S. Naval Academy

11. Industry or business

Retired

MOTHER FATHER

12. Name August Swenson13. Birthplace Sweden14. Maiden name —15. Birthplace —16. Informant Catherine A. SwensonAddress 53 Fleet St. Annapolis, Md.17. Burial Date thereof Nov. 19, 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar BluffLocation Annapolis, Md.18. Funeral director John M. Taylor & SonAddress Annapolis, Md.19. Nov. 19 48 John M. Taylor & Son  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. 53 Fleet St  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1621. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16 - 7 pm to Nov. 16 - 9 pmand that I last saw him alive on Nov. 16 19 48

Immediate cause of death

Coronary thrombosisDue to Arteriosclerosis

Due to

Other conditions Myocarditis Chr.

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

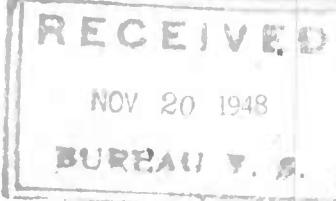
Means of injury

Injured at work?

23. SIGNATURE George L. Board

M. D. or other

Address Annapolis, Md. Date signed Nov. 18, 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, in correct age. is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

11133

21

Reg. Dist. No. ....

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County

Anne Arundel

City or town

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

13 hours 75 minutes

Hospital, institution, or street address where death occurred:

Annapolis Emergency Hospital

How long in hospital or institution?

13 hours 75 minutes

## 3. (a) FULL NAME

Selina Thompson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

negro

widow

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age .....

years

June 1, 1888

8. AGE:

Years 60

Months 5

Days 16

If less than one day

hrs.

min.

9. Birthplace

Churchton A.R.C., Maryland

(Town, county, and state)

10. Usual occupation

Housewife

Home

11. Industry or business

Gassaway Holland

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Marcellus Thompson

Address 1127 - 9. St. N.E. Washington D.C.

17. Burial

Date thereof 1950. 26. 9. 48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

John M. Caffey, M.D.

19. November 18 1948

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For a born infant, give residence of mother)

State

Maryland

County

Anne Arundel

City or town

Churchton

Street No.

Main Highway

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 17 1948 5<sup>20</sup> A.M.

21. I CERTIFY that death occurred on the date above stated:

Postmortem Examination

Nov. 17 1948

Immediate cause of death

Shock

Internal injuries

Abdominal

Hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

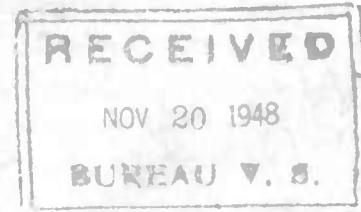
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date ofWhere did injury occur? Churchton A. A. Maryland (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Man Haly Churchton (Injured at work?) noMeans of injury automobile struck her Deputy medicalInjured at work? no John M. Caffey, M.D. Examiner M. D. or otherAddress Annapolis Md Date signed 11-17-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

30d  
11134

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

## 1. PLACE OF DEATH:

Anne Arundel  
County  
City or town Fort Meade

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Fort Meade Hospital

How long in hospital or institution? 10 days

## 3. (a) FULL NAME

Eunice Edna Sipton

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F W Married

6. (b) Name of husband or wife John V. Sipton

7. Birth date of deceased (mo., day, yr.)

July 24, 1916

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

32

3

17

hrs.

min.

9. Birthplace

Union Town, Alabama

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

None

MOTHER

12. Name Bert McQuinn

13. Birthplace

Mississippi

14. Maiden name

Hannie Combs

15. Birthplace

Mississippi

16. Informant

Sgt. John V. Sipton

Address

Fort Meade, Maryland

17. Burial

Date thereof Nov. 14, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Riverdale Cemetery

Location

Columbus, Georgia

18. Funeral director

DeWitt Donaldson

Address

Laurel, Maryland

12 Nov

(Date rec'd by registrar)

48

JAMES. N. GOERGER

Capt.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Fort Meade

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

November 11, 1948, at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19, 1948, to Nov. 10, 1948, and that I last saw h.c. alive on Nov. 10, 1948.

Immediate cause of death

Myocardial Infarction secondary to Coronary Occlusion

Due to Stenosis of Coronary Arteries

Due to Luetic Aortitis (Syphilitic Aortitis) UnKnown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results Autopsy Refused

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

MERLETT E. GOERGER, Capt. or other, Capt. M.D., A.M.

MSC

Address

Fort George G. Meade, Md. Date signed 12 Nov 48

